HCC Medical Insurance Services, LLC
251 North Illinois Street, Suite 600, Indianapolis, Indiana 46204 USA
main 317 262 2132 facsimile 317 262 2140 toll free 800 605 2282
hccmis.com orders@hccmis.com

Atlas MultiTrip™

Atlas MultiTrip International – For Travel Outside of the U.S.		
Maximum Trip Duration	**30 Days per Trip**	**45 Days per Trip**
Participant - Annual Premium	$200	$245
Spouse and up to two children*	$100	$122
Each additional child*	$40	$49

Atlas MultiTrip America – For Non-U.S. Citizens Traveling to the U.S.		
Maximum Trip Duration	**30 Days per Trip**	**45 Days per Trip**
Participant - Annual Premium	$285	$350
Spouse and up to two children*	$145	$180
Each additional child*	$57	$70

Rates are shown in US dollars and are effective 04/01/15. Rates are subject to change. Surplus Lines taxes and fees will be charged when applicable.

Eligibility for Atlas MultiTrip policy coverage requires that each applicant's age be between 14 days and up to 75 years of age.
*Children under 19 years of age

Premiums are fully earned on the Certificate Effective Date and are nonrefundable thereafter.

ATLAS MULTITRIP™ APPLICATION
HCC Medical Insurance Services
Lloyd's Coverholder
Please print clearly and provide complete information.

1. **Please select your area of coverage:** **Excluding the U.S.** **Including the U.S.** (Available to Non-US citizens and residents only)

2. **Destination Country:** _____ and **Home Country:** _____

3. **Start Coverage Date (mm/dd/yyyy):** ___/___/_____

4. **I understand this 364-day policy provides coverage for trips of short durations as selected below.** **Yes**

5. **Select Trip Duration** (See attached Rate Sheet for the applicable trip duration rates): **30-days or less** **45-days or less**

6. **Do you maintain medical insurance coverage in your Home Country?** **No** **Yes**

7. **Beneficiary:** _____

Please print information for **all** individuals to be covered. In lieu of table below, this applicant list may be submitted by attaching a spreadsheet.

	Name (Last, First)	Birthdate (mm/dd/yyyy)	Gender	Citizenship	Annual Premium
Insured:		/ /			
Spouse:		/ /			
Child 1:		/ /			
Child 2:		/ /			
Child 3:		/ /			

Premium Subtotal (A): _____

Florida Surplus Tax: Will your group be traveling to Florida to work? If yes, multiply **Line A by 1.05175 (B):** _____

Total Amount Due (A + B): _____

Form of Payment: ☐ Credit Card ☐ Check/Money Order		Name on card & Mailing Address:	Billing Address & daytime phone:
Email Address:			
Credit Card #:	Expiration Date (mm/yy):		
Signature:			

Payment by Credit Card: By signing above, the cardholder authorizes HCC Medical Insurance Services to debit his or her Discover, VISA, MasterCard or American Express account for the amount specified above. Please submit this completed Application by mail or by fax to your Agent or to HCCMIS.
HCC Medical Insurance Services
251 North Illinois Street, Suite 600
Indianapolis, IN 46204

Checks and Money Orders should be made payable to HCC Medical Insurance Services. Please send your Check or Money Order along with this Application via mail or courier to:
Bank of America Lockbox Services
c/o Lockbox # 15748
540 W. Madison 4th Floor
Chicago, IL 60661

Total payment for the initial term of coverage requested must be entirely paid in U.S. dollars at time of application or prior to the Effective Date of Coverage. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda, and for the insurance provided to members by Lloyd's. I understand that the insurance applied for is not a general health insurance policy, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country. I understand that my insurance terminates upon my return to my Home Country unless I qualify for a Benefit Period or Home Country Coverage. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Penalty and other restrictions and exclusions. I understand that if I am eligible for extensions and renewals of this insurance, they may only be transacted online and will not be effective unless such transaction is confirmed in writing by HCC Medical Insurance Services, and I understand that renewals may be transacted only within the thirty (30) days immediately preceding my current coverage's expiration date. I understand that the information contained herein is a summary of the Master Policy and that I may obtain a complete copy of the Master Policy upon request to HCC Medical Insurance Services. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand and agree that the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant. Licensed insurance brokers and independent agents are compensated through commissions calculated as a percentage of premium for the purchase, renewal, placement or servicing of insurance coverage. Additionally, some licensed producers may also receive bonuses and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume or for the percentage of completed sales through HCC Medical Insurance Services. Please contact your insurance broker to obtain information about the specific compensation they may receive in connection with the issuance of your coverage. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant.

Signature of Applicant:	Date of Signature:
Signature of Spouse:	Date of Signature:

For more information or for assistance completing this application, please contact: **Producer Number:** 23566

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