

HealthCare International Premiums

For Policies with Effective Dates
through December 31, 2007

Age of Applicant	Persons to be Insured	Monthly Premiums		
		Area A	Area B	Area C
0-25	Adult	\$ 90	\$ 113	\$ 180
26-39	Adult	\$ 102	\$ 128	\$ 205
40-54	Adult	\$ 133	\$ 167	\$ 267
55-70	Adult	\$ 236	\$ 354	\$ 472
	Dependent			
	Child	\$ 58	\$ 70	\$ 115

Definition of Dependent Child

Unmarried child declared on the Application, between 15 days and under 20 years of age, traveling or residing with their parent(s) outside their home country.

Optional: \$100,000 Accidental Death & Dismemberment Benefit: \$15 per month (Available only for persons age 18 or older)

The premium calculation is based upon the Applicant's age, destination area (A, B or C) and the length of time to be insured. The minimum renewal premium is three (3) times Monthly Premium even if less than three months of insurance is requested.

Area A includes those countries within Europe, Central America, South America and elsewhere in the world not specifically named under Areas B and C.

Area B includes Africa (every country located on the continent of Africa and the islands of Madagascar and the Seychelles; Russia and the Newly Independent States (formerly the USSR); Middle East and Asia.

Area C includes the United States (its possessions and territories), Canada, the Caribbean Islands and Bermuda.

Please see the Definitions and Administration for more precise details on the countries included within Areas A, B and C.

If you are traveling to more than one area or to an area where civil unrest exists, please call the Administrator for the appropriate premium.

Administered by:

Wallach
& COMPANY, INC.

"Smart" insurance for informed travelers.™

107 West Federal Street
Post Office Box 480

Middleburg, Virginia 20118-0480 USA

Telephone:

(800) 237-6615 or (540) 687-3166

Fax: (540) 687-3172

Email: info@wallach.com www.wallach.com

HealthCare International RENEWAL APPLICATION



HealthCare International RENEWAL APPLICATION

Applicant

Name _____

Birth Date _____ / _____ / _____

Address _____

Email Address _____

Nationality _____ Passport No. _____

Purpose of Travel _____

Destination Country(ies) _____

Name of Emergency Contact in Home Country _____ Relationship _____

Telephone Number of Emergency Contact in Home Country _____

Information on Spouse/Family

(if they are to be insured)

Spouse (Name) _____

Sex: M F _____
Birth Date _____ / _____ / _____

Child (Name) _____

Sex: M F _____
Birth Date _____ / _____ / _____

Child (Name) _____

Sex: M F _____
Birth Date _____ / _____ / _____

Child (Name) _____

Sex: M F _____
Birth Date _____ / _____ / _____

Premium Calculation

(see monthly premiums on back of this application)

\$ _____ Monthly Premium

+ \$ _____ Optional Monthly AD&D Premium

= \$ _____ Total Monthly Premium

X _____ Number of Months Requested
(12 month maximum)

= \$ _____ **Total Policy Premium** The minimum renewal policy premium is three (3) times the total monthly premium, even if less than three months of insurance is requested.

_____ / _____ / _____ Requested Effective Date The effective date of the insurance cannot be prior to the date this Application and premium are received and approved by the Administrator.

Payment

Check/Money Order payable in U.S. funds, drawn on a U.S. bank, and made payable to **Wallach & Company, Inc.**

VISA American Express MasterCard

Card Number _____

Name on Credit Card _____

Expiration Date _____ / _____

Signature _____

Declaration of Applicant

Have you or your dependents submitted or plan to submit any claims for medical expenses which were incurred prior to the renewal of this insurance? Yes No

I declare that the information given in this Application is true and complete. I understand (on behalf of the person(s) to be insured) that this insurance will not cover treatment arising from any diseases, injuries or medical conditions known to exist within the one year period immediately prior to the original effective date of this insurance. It is agreed that this declaration and the information given herein shall form the basis of the contract between the Insured Person and the Company.

Signature of Applicant _____

Date _____ / _____ / _____

Application and all correspondence should be mailed or faxed to:

Wallach & Company, Inc.
107 West Federal Street
Post Office Box 480
Middleburg, Virginia 20118-0480 USA
Fax: (540) 687-3172