

## HealthCare International Premiums

For Policies with Effective Dates  
through December 31, 2006

Age of Applicant	Persons to be Insured	Monthly Premiums		
		Area A	Area B	Area C
0-25	Adult	\$ 78	\$ 98	\$ 156
26-39	Adult	\$ 89	\$ 111	\$ 178
40-54	Adult	\$ 116	\$ 145	\$ 232
55-70	Adult	\$ 205	\$ 308	\$ 410
	Dependent			
	Child	\$ 50	\$ 60	\$ 100

### 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: \$12 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

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## 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**