Health Plan Administrators
Independence Holding Group

Overseas Travel Medical Plan

Underwritten by
United States Fire Insurance Company

Application for coverage and plan rates

APPLICANT

PRINT YOUR NAME BELOW *(As it appears on your Passport):*

(Last) _____

(First) _____ (Middle) _____

PASSPORT NUMBER: _____

SEND CONFIRMATION TO:

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Telephone: _____

Fax: _____

Email: _____

***REQUESTED EFFECTIVE DATE:** _____

***DEPARTURE DATE:** _____

*(*At no time will the effective date be earlier than the date received by HPA, Inc.)*

DATE OF RETURN TO HOME COUNTRY: _____

COUNTRY OF CITIZENSHIP: _____

COUNTRIES TO BE VISITED: _____

NAME OF BENEFICIARY:

(Last) (First) (Middle)

_____

(You will be the Beneficiary for Your spouse and dependent children included on this Application.)

LIST THE NAMES OF INDIVIDUALS FOR BENEFITS, and the appropriate cost for the Plan and Options selected: *(Please attach additional sheet if necessary)*

Name	Date of Birth	Monthly Cost	Daily Cost
Applicant: Gender: Male □ Female □			
Spouse: Gender: Male □ Female □			
Child: Gender: Male □ Female □			
Child: Gender: Male □ Female □			
Subtotal:			

COVERAGE

SELECT ONE PLAN OPTION ONLY:

Benefits for U.S. Citizens outside of the United States:

□ **$50,000** □ **$100,000** □ **$250,000** □ **$1,000,000**

Benefits for Non-U.S. Citizens while in the United States:

□ **$50,000** □ **$100,000** □ **$250,000** □ **$1,000,000**

SELECT ONE DEDUCTIBLE OPTION ONLY:

□ **$0** □ **$125** □ **$250**
□ **$500** □ **$1,000** □ **$2,500**

FOR AGENT USE ONLY

HPA Agent #: _____

Agent name: _____

Address: _____

City: _____

State: _____

Zip: _____

Telephone: _____

Fax: _____

Email: _____

GA name: _____

HPA #: _____

MGA name: CSA GENERAL AGENCY

HPA #: CSA3200000

ACKNOWLEDGEMENT AND AUTHORIZATION

READ AND SIGN BELOW: I understand that this is not a general health insurance policy and that it is intended for use in the event of a sudden and unexpected event while I am traveling outside of my Home Country. I understand that Pre-existing Conditions are not covered. I understand this Plan contains a Pre-notification Penalty, and other restrictions and exclusions. I understand this Plan is not renewable and successive terms of protection will require re-satisfaction of the Deductible and Coinsurance. The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis or physical or mental condition of any person listed on this Application to release said information to Health Plan Administrators, Inc.

_____

Signature of Applicant (or Guardian) Date

_____

Signature of Spouse Date

Complete provisions pertaining to this insurance are contained in the Master Policy (Form # IN/OUT-04) on file with the Trustee, American Consumer Insurance Trust. Overseas Travel Medical is underwritten by United States Fire Insurance Company.

Notice to residents of Florida: This plan is underwritten by United States Fire Insurance Company and is governed by the law of a state other than Florida. Your homeowner's policy, if any, may provide coverage for loss of personal effects provided by the baggage and personal effects benefits. For US Residents: This insurance is not required in connection with the purchase of Your travel arrangements.

Notice to residents of California: This plan contains disability benefits or health benefits, or both, that only apply during Your trip. You may have coverage from other sources that already provide You with these benefits. You should review Your existing policies. If You have any questions about Your current coverage, call Your insurer or health plan administrator. Note, in California, the Pre-Existing condition limitation is waived for medical expenses.

Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

The reverse side of this application contains rates and calculation instructions.

OVERSEAS TRAVEL MEDICAL PLAN COST CALCULATION AND RATES

PLAN COST CALCULATION CHART

Enter plan cost for ONE month: $ _____

Enter plan cost for ONE day $ _____

Only for Payment in Full****

Multiply by # of Days _____ X $ _____

Subtotal: $ _____

If other than $250 Deductible Selected, Multiply subtotal by Factor Indicated Below: (skip if $250 Deductible selected)

$0 x 1.30 =$ _____

$125 X 1.20 =$ _____

$500 X .90 =$ _____

$1,000 X .80 =$ _____

$2,500 X .70 =$ _____

Optional Sports Rider Multiply **X 1.15*** =$ _____

**Administration Fee

$10.00 X _____ months: =$ _____

***Optional: ship policy overnight charge:**+ $15.00* =$ _____

Total Amount Due: =$ _____

***If you choose Monthly Pay as you go, the $10.00 Administration fee is charged monthly. If you choose Single pay, the $10.00 administration fee is charged one time only.*

****The overnight shipping charge overseas is $25.00.*

*If you are purchasing the Hazardous Sports Rider, please describe the activities for which you are seeking benefits: _____

COMPLETE THE FOLLOWING:

□ Payment in Full **** **(up to 12 months)**

□ Monthly Pay as you go* **(up to 12 months)**

****Must use daily rate if Payment in Full option selected*

COMPLETE PAYMENT MODE:

□ Check / Money Order □ Monthly Automatic Bank Draft

□ MasterCard □ Visa □ Discover

**If You selected Monthly Pay as you go, You must also complete either the Automatic Bank Draft Request or Credit Card Request. Daily must be paid in full*

All payments by check must be made in U.S. dollars.
Make checks payable to and mail to:
Health Plan Administrators, Inc. (HPA)
P.O. Box 15250, Rockford, IL 61132-5250
You can save on postage if you pay by credit card. Simply fax both sides of the completed application to:
1-815-633-0277

METHOD OF PAYMENT REQUESTED

□ Monthly for the 12 months of plan cost and administration fee
□ Only for # _____ days for Payment in Full

CREDIT CARD REQUEST:

Credit Card #: _____

Expiration Date: _____

Name as it appears on card: _____

Billing Address: _____

Day phone #: _____

Signature: _____

IF PAYING BY CREDIT CARD:

I authorize Health Plan Administrators, Inc. to debit my VISA, MasterCard or Discover account for the total due amount specified by me. I understand that benefits purchased by credit card are subject to validation and acceptance by the credit card company.

AUTOMATIC BANK DRAFT REQUEST:

By selecting automatic check withdrawal, Your monthly Plan Cost will automatically be withdrawn from Your checking account. Complete the form below.

To: (Bank name): _____

Address: _____

I request that you pay and charge my account debits drawn from my account by Health Plan Administrators, Inc. to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advanced written notice to me and to Health Plan Administrators, Inc. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my Plan.

Signature of Plan Payer Date

Cost for the $250 deductible effective 1-09

US Citizens — Outbound

Available from 5 days to 12 months, Payment in full or Monthly Pay

Limit	$50,000		$100,000		$250,000		$1,000,000	
Age Bands	Monthly	Daily	Monthly	Daily	Monthly	Daily	Monthly	Daily
Child Alone**	$29	$0.97	$34	$1.13	$37	$1.23	$45	$1.50
19 - 29	$30	$1.00	$35	$1.17	$38	$1.27	$47	$1.57
30 - 39	$36	$1.20	$42	$1.40	$52	$1.73	$63	$2.10
40 - 49	$60	$2.00	$68	$2.27	$74	$2.47	$85	$2.83
50 - 59	$103	$3.43	$117	$3.90	$122	$4.07	$133	$4.43
60 - 64	$128	$4.27	$154	$5.13	$164	$5.47	$188	$6.27
65 - 69	$150	$5.00	$166	$5.53	$173	$5.77	$194	$6.47
70 - 79	$223	$7.43	$310	$10.33	N/A	N/A	N/A	N/A
80 +***	$385	$12.83	N/A	N/A	N/A	N/A	N/A	N/A
Dep. Child	$21	$0.70	$26	$0.87	$30	$1.00	$32	$1.07

Cost for the $250 deductible effective 1-09

Non-US Citizens (foreign visitors) - Inbound

Available from 5 days to 12 months, Payment in full or Monthly Pay

Limit	$50,000		$100,000		$250,000		$1,000,000	
Age Bands	Monthly	Daily	Monthly	Daily	Monthly	Daily	Monthly	Daily
Child Alone***	$47	$1.57	$55	$1.83	$60	$2.00	$80	$2.67
19 - 29	$48	$1.60	$56	$1.87	$61	$2.03	$83	$2.77
30 - 39	$64	$2.13	$74	$2.47	$83	$2.77	$110	$3.67
40 - 49	$95	$3.17	$107	$3.57	$118	$3.93	$158	$5.27
50 - 59	$145	$4.83	$175	$5.83	$197	$6.57	$246	$8.20
60 - 64	$175	$5.83	$218	$7.27	$247	$8.23	$308	$10.27
65 - 69	$222	$7.40	N/A	N/A	N/A	N/A	N/A	N/A
70 - 79	$280	$9.33	N/A	N/A	N/A	N/A	N/A	N/A
80 +***	$484	$16.13	N/A	N/A	N/A	N/A	N/A	N/A
Dep. Child	$29	$0.97	$33	$1.10	$34	$1.13	$46	$1.53

**Outbound coverage not available in all states. See www.hpainsurance.com or call 1-800-277-3323 ext. 3 for details.*

***If more then one child (siblings) for "Child alone" coverage, the oldest child (sibling) should pay the "Child alone" rate and the rest of the siblings the "Dependent child" rates.*

****$10,000 Maximum Limit for ages 80 and older.*