ECG Travel Application

Purchaser Information

First Name _____

Last Name _____

Date of Birth (MM/DD/YYYY) _____

Address _____

City _____

State _____ Zip _____

Email _____

Daytime Telephone Number _____ Fax Number _____

Destination _____

Departure Date (MM/DD/YYYY) _____ Return Date (MM/DD/YYYY) _____

When did you make the deposit on your trip? (MM/DD/YYYY) _____

q Tour/Cruise Company _____

q Airline _____

Preferred Method of Confirmation: Email Mail Fax

Additional Insureds Information

Insured #2 First Name _____

Insured #2 Last Name _____

Date of Birth (MM/DD/YYYY) _____

Insured #3 First Name _____

Insured #3 Last Name _____

Date of Birth (MM/DD/YYYY) _____

Insured #4 First Name _____

Insured #4 Last Name _____

Date of Birth (MM/DD/YYYY) _____

A. If individuals within your family have different trip costs, please use the average trip cost to determine the coverage level per person. $ _____ ÷ _____ = $ _____ Total trip cost # of insureds Coverage level per person

B. Locate the price from the brochure or website based on age and, if applicable, the coverage level per person from section A above.

Purchaser $ _____ Rate Insured #2 $ _____ Rate Insured #3 $ _____ Rate Insured #4 $ _____ Rate

C. Add optional Required to Work for each insured adult age 18 or older or add optional Cancel Anytime coverage: Required to Work x $25.00 = $ _____ _____ _____ # of adults Rate Cancel Anytime x 30% = $ _____ _____ _____ section B total Rate The maximum trip cost/coverage for Cancel Anytime is $10,000. You can only select one optional program under section C.

D. Add optional Rental Car Protection (not available to Texas residents): x $9.00 = $ _____ _____ _____ # of days Rate (min. of 2 days)

E. For trips over 30 days ONLY. Count your departure and return days as travel days. $3.00 x x = $ _____ _____ _____ _____

Daily rate # of days # of people

Rate over 30 on policy

F. Calculate total payment (B+C+D+E): $ _____

G. Choose your payment method (check one) American Express Discover Card MasterCard VISA

Card Number

_____ CW#_____

Expiration Date (MM/YY) _____

Print Name _____

By signing below I acknowledge that certain benefits may not be payable due to Existing Medical Conditions or foreseeability of loss at time of purchase. There is an one time application fee of $25.

_____

Signature of Enrollee & Date

PLEASE SUBMIT ALL APPLICATION FOR QUOTE TO NEWBUSINESS@CONSULTWITHEDMOND.COM OR FAX THE DOCUMENTS TO (803) 234-5004.