TravelInsuranceCenter

FAX TO: 1-402-343-9959
Source ID: SHPKIWI

liaison® traveler application

Effective January 1, 2007

(please print or type using black ink)

Official Use Only:

Cert#: Processed: Eff. Date: Agent: **6887**

applicant information

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms

Last Name: _____

First Name: _____ M.I. _____

Date of Birth: ____/____/____ *(month/day/year)*

Passport Number: _____

Issuing Country: _____

What do you consider your Home Country or Fixed Permanent Residence?

_____

address of correspondence

Address: _____

City: _____ State: _____

Postal Code: _____ Country: _____

Work Phone: ( ) _____ Home Phone: ( ) _____

Email Address: _____

for ad&d benefit:

Beneficiary: _____

Relationship: _____

for couple or family coverage

Names of additional persons to be insured? Date of Birth

Spouse: _____ _____/_____/_____

Child: _____ _____/_____/_____

Child:: _____ _____/_____/_____

Child:: _____ _____/_____/_____

Child:: _____ _____/_____/_____

(please attach separate sheet for additional children)

have you purchased insurance through seven corners before?

❑ Yes ❑ No

requested effective date of coverage:

Month: _____ Day: _____ Year: _____

**Note: Coverage cannot begin until Seven Corners receives your application and correct premium.*

calculating your premium

Select Period of Coverage:

❑ 3-Months ❑ 6-Months ❑ 12-Months

select plan type:

❑ Single (applicant only) ❑ Couple ❑ Family

(Be sure to use correct premium)

premium

Standard Program $ _____

standard upgrade options *(if applicable)*

option a

Add Medical Coverage *(no coverage in U.S.)*
(max. 60 days any one trip) $ _____

option b

Increase Primary AD&D to: $ _____ $ _____

Plus Admin Fee: $ 10.00
(non-refundable)

Total Payment Enclosed: $ _____

method of payment

❑ MasterCard

❑ Visa ❑ Discover ❑ American Express

Card Number: _____ CVC Number: _____

Expiration Date: _____ Daytime Phone: ( ) _____

Name as it appears on Card: _____

Signature *(Required)* _____

Billing Address: _____

Only one Liaison Traveler program may be purchased for any given policy period. Make Check or Money Order payable to: "Seven Corners". Total Payment for the Full Term of coverage requested must be paid in U.S. dollars at the time application for coverage is made. Coverage purchased by credit card is subject to validation and acceptance by credit card company.

I declare that I understand the terms and conditions of this product, as outlined in this brochure. I hereby subscribe to the AIG Life Trust and enroll in the group coverage for which I am eligible under the group contract issued by The Insurance Company of the State of Pennsylvania, a member of American International Group, Inc. (AIG).

_____

Signature of Insured or Proxy *(Required)* Date

liaison traveler 200701