HCC Medical Insurance Services, LLC
251 North Illinois Street, Suite 600, Indianapolis, Indiana 46204 USA
main 317 262 2132 facsimile 317 262 2140 toll free 800 605 2282
hccmis.com service@hccmis.com

Atlas MultiTrip™

Atlas MultiTrip International		
Maximum Trip Duration	**30 Days per Trip**	**45 Days per Trip**
Participant - Annual Premium	$200	$245
Spouse – Annual Premium	$100	$122
Child – Annual Premium	$40	$49
*Family (participant + spouse + 2 children)	$300	$367

Atlas MultiTrip America		
Maximum Trip Duration	**30 Days per Trip**	**45 Days per Trip**
Participant - Annual Premium	$285	$350
Spouse – Annual Premium	$145	$180
Child – Annual Premium	$57	$70
*Family (participant + spouse + 2 children)	$430	$530

Rates are effective 4/1/2014 and subject to change.

*If Family Plan is chosen, each extra child (under age 19) added after the first 2 children will be charged the Child rate on the policy.

Rates do not include Surplus Lines taxes and fees; however, Surplus Lines taxes and fees may be added to rates when applicable.

Premiums are non-refundable after departure from Home Country. All premiums are considered fully earned once your Policy becomes effective. Prior to your effective date, you may notify us in writing for a refund. Additional cancellation fees may apply.

ATLAS MULTITRIP™ APPLICATION
HCC Medical Insurance Services
Lloyd's Coverholder
Please print clearly and provide complete information.

1. **Please select your area of coverage:**
   Excluding the US
   Including the US *Available to Non-US citizens and residents only

2. **I understand this 364-day policy provides coverage for trips of short durations as selected below. Yes**

3. **Select Trip Duration** (See attached Rate Sheet for the applicable trip duration rates):
   30-days or less
   45-days or less

4. **Do you maintain medical insurance coverage in your Home Country? No Yes**

Please print information for **all** individuals to be covered. In lieu of table below, this applicant list may be submitted by attaching a spreadsheet.

	Name (Last, First)	Birthdate (mm/dd/yy)	Gender	Citizenship	Annual Premium
Insured:		/ /			
Spouse		/ /			
Child 1		/ /			
Child 2		/ /			
Child 3		/ /			

Premium Subtotal (A): _____

Florida Surplus Tax: Will your group be traveling to Florida to work? If yes, multiply **Line A by 1.05175 (B):** _____

Total Amount Due (A + B): _____

Form of Payment: ☐ Credit Card ☐ Check/Money Order		Name as it appears on card:
Credit Card #:	Expiration Date (mm/yy):	Complete Billing Address (include daytime phone #):
Signature:		

Payment by Credit Card: By signing above, the cardholder authorizes HCC Medical Insurance Services to debit his or her Discover, VISA, MasterCard or American Express account for the amount specified above. Please submit this completed Application by mail or by fax to your Agent or to HCCMIS.
HCC Medical Insurance Services
251 North Illinois Street, Suite 600
Indianapolis, IN 46204

Checks and Money Orders should be made payable to HCC Medical Insurance Services. Please send your Check or Money Order along with this Application via mail or courier to:
Bank of America Lockbox Services
c/o Lockbox # 15748
540 W. Madison 4th Floor
Chicago, IL 60661

Total payment for the initial term of coverage requested must be entirely paid in U.S. dollars at time of application or prior to the Effective Date of Coverage. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

The Sponsoring Organization (Sponsor), on behalf of and as authorized agent and proxy for each of the group participants listed on the Application, hereby applies for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda, and for the insurance provided to members by Lloyd's. The Sponsor and all group participants understand that the insurance applied for is not a general health insurance policy, but is intended for use by members in the event of a sudden and unexpected event while traveling outside their Home Country(ies). The Sponsor and all group participants understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Penalty and other restrictions and exclusions. The Sponsor and all group participants understand that coverage under this insurance is not renewable and successive periods of insurance will require re-satisfaction of the Deductible, Coinsurance, Pre-existing Condition provision, and all other conditions of the insurance following acceptance of a new Application. The Sponsor and all group participants understand that the information contained herein is a summary of the Master Policy and that they may obtain a complete copy of the Master Policy upon request to HCC Medical Insurance Services. The Sponsor and all group participants understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. The Sponsor and all group participants understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. The Sponsor and all group participants understand and agree that the insurance agent/broker, if any, assisting with this Application is their representative. Licensed insurance brokers and independent agents are compensated through commissions calculated as a percentage of premium for the purchase, renewal, placement or servicing of insurance coverage. Additionally, some licensed producers may also receive bonuses and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume or for the percentage of completed sales through HCC Medical Insurance Services. Please contact your insurance broker to obtain information about the specific compensation they may receive in connection with the issuance of your coverage. If signed by a representative of the Sponsor, the undersigned warrants his/her capacity to so act. If signed as Sponsor, the undersigned warrants his/her authority to so act. By acceptance of coverage and/or submission of any claim for benefits, the each group participant ratifies the authority of the signer to so act and bind the group participant.

Signature of Applicant:	Date:
Signature of Spouse:	Date:

For more information or for assistance completing this application, please contact: **Producer Number:** 24260

DNP INSURANCE SERVICES / DNP & Associates, Inc. / 14541 Brookhurst St. Ste. C2
Westminster, CA 92683 USA
Phone: 714-531-8750 || Fax: 714-531-8752
E-mail: dnpinsurance@yahoo.com
www.dnpGlobal.com