

ATLAS APPLICATION
HCC Medical Insurance Services
Lloyd's Coverholder

Print all names as you would like them to appear on your Identification Cards.
Please print clearly and provide complete information.

Last Name		First Name		MI
Complete Mailing Address for all correspondence:				
Telephone #:		Fax #:		E-mail Address*:
Requested Effective Date (mm/dd/yy):		Departure Date (from Home Country):		Date of Return to Home Country:
Countries to be visited:				
Name of Beneficiary:			Relationship to Applicant:	
(Note: You will be the Beneficiary for spouse and dependent children included on this Application.)				

***REQUIRED FOR EXTENSION OF COVERAGE NOTIFICATION**

OPTION(S) SELECTED: [] (Maximum of 2 options when there are multiple citizenships)

Names of all individuals to be covered. List applicable rates for the option chosen:					Column <u>M</u>	Column <u>R</u>
#	Name (Last, First)	Birth Date (mm/dd/yy)	Citizenship	Passport Number	Monthly Rate	Daily Rate
1						
2						
3						
4						

Florida Surplus Lines question (for all Atlas America applicants only): Are you traveling to Florida to work? Yes No

A	Subtotals (add lines 1 through 4 above)	A		
B	Trip Duration (# of Months and/or # of Days)	B		
C	Multiply Line A by Line B	C		
D	Enter Deductible Factor (from Deductible Factor Table)	D		
E	Multiply Line C by Line D	E		
F	Enter Factor for Hazardous Sports Rider, if Selected (1.20), otherwise Enter 1.0	F		
G	Multiply Line E by Line F	G		
H	Add Column <u>M</u> Line G to Column <u>R</u> Line G, (TOTAL Premium Due)	H		
I	OPTIONAL Express Delivery Charge: Add \$20.00 for US Delivery, \$30.00 Non-US Delivery	I		
J	Add Line H and Line I together (TOTAL Amount Due)	J		

Payment Mode: <input type="checkbox"/> Check/Money Order <input type="checkbox"/> Discover Card <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> American Express	Credit Card #:	Expiration Date (mm/yy):
Name as it appears on card:	Complete Billing Address:	
Daytime Phone #:	Signature:	

Check or Money Orders should be made payable, in US dollars, to HCC Medical Insurance Services. If paying by credit card, I authorize HCC Medical Insurance Services to debit my Discover, VISA, MasterCard or American Express account for the amount specified above. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. 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.

I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda and for the insurance provided to members by Lloyd's. I understand that the insurance applied for is not a general health insurance policy, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Penalty and other restrictions and exclusions. I understand that if I am eligible for extensions and renewals of this insurance, they may only be transacted online and will not be effective unless such transaction is confirmed in writing by HCC Medical Insurance Services, and I understand that renewals may be transacted only within the thirty (30) days immediately preceding my current coverage's expiration date. I understand that the information contained herein is a summary of the Master Policy and that I may obtain a complete copy of the Master Policy upon request to HCC Medical Insurance Services. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I 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. I understand and agree that the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant. 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 Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant.

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

For more information or for assistance completing this application, please contact:

Producer Number: _____