INDIA NETWORK SERVICES
INDIA NETWORK HEALTH INSURANCE ENROLLMENT FORM
Underwritten By the Insurance Company of the State of Pennsylvania
Fax the completed form to: 407-479-3289

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____ Country _____

Home Phone_____ Work Phone _____

Passport Number:_____ Birth Date (mm/dd/yy) _____ Gender: _____

Home Country: _____ Host Country: _____Arrival Date: _____

E-mail Address: _____

List Dependents to be insured below (IF ANY). Dependent coverage is available only if a parent/spouse is also insured.

Relation	Last Name	First Name	Date of Birth
Spouse			
Child1			
Child2			

Payment Instructions: Consult the chart for premiums and make check or money order made payable to 'India Network Services' in US Dollars. Mail this enrollment form with the premium payment to India Network, 7065 Westpointe Blvd, Suite 201, Orlando, FL 32835 or fax to 407-479-3289 if paying by credit card.

Check one per line
Policy Maximum **[ ] $50,000 [ ] $100,000 [ ] $150,000**

Choose Deductible **[ ] $75 [ ] $250 [for 2 to 69 Yr old]**
[ ] $250 [ ] $500 (for 70+ only)

Pre-existing Coverage Rider: [ ] Yes [ ] No

Payment Information: I am enclosing a check for the amount of $ _____ Or

I hereby authorize charge of Total Premium $_____(Calculate from the Website or call our office)

Credit card # (MC/VISA/AMEX/DISC) _____ Exp. Date:___/___ Vcode: _____

Cardholder's Signature _____ Date ___/___/___

PERIODS OF COVERAGE: I want my coverage to begin on ____/____/____ and continue for ____ months ___ days.

Important: Coverage will be effective on the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy GLB9124105/9124106/9124107. It is the Insured's responsibility to timely submit renewal payments. By signing below, the visitor acknowledges the following: (1) He/She has carefully read, understands, and agrees to the terms and conditions of the coverage including the pre-existing condition limitations and elects to enroll as indicated on this enrollment form; (2) Rates are not prorated other than as listed on this enrollment form; (3) He/She meets the eligibility requirements for this coverage as described in the program description; (4) if it is later determined that the visitor is not eligible, the premium will be refunded; and (5) I have read, understood and agree with the cancellation policy that no refunds after effective date.

Signature of Enrollee: _____ Date ____/____/____
(Or Person completing the form)

Name of the India Network Member:_____

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