INBOUND®
GUEST

MEDICAL BENEFITS FOR NON-U.S. CITIZENS VISITING THE U.S.

emergency medical evacuation • repatriation • 24 hour assistance service

SEVENCORNERS

ELIGIBILITY

WHO CAN BUY INBOUND® GUEST?

You are eligible for coverage if you are a non-United States citizen traveling to the U.S. for business, pleasure, or to study. Your coverage must become effective within 180 days of your arrival in the United States.

It is your responsibility to maintain all records regarding travel history and age and provide necessary documents to Seven Corners to verify eligibility if required.

LENGTH OF COVERAGE

Your coverage length may vary from 5 days to 180 days. You have the option to renew coverage in any increment of 5 days or more (there is a $5 fee each time you renew). You may apply for a new period of coverage after 180 days if you return to your home country before doing so.

Coverage Start Date - Coverage will not begin until you leave your home country, and we receive your application and premium. This is your effective date.

Coverage Expiration Date - Your coverage ends at 12:01 AM North American Eastern Time on the earlier of the following: the date you return to your home country; 180 days after your effective date; the expiration date on your ID card; the day you become a U.S. citizen or enter into active military service.

YOUR INSURANCE COMPANY

Inbound® Guest is underwritten by Certain Underwriters at Lloyd's of London and is rated A "Excellent" by A.M. Best. In addition to being one of the largest insurance entities in the world, Lloyd's has over 300 years of experience in the international insurance business.

SEVEN CORNERS, YOUR PROGRAM ADMINISTRATOR

Seven Corners* has administered Inbound® Guest since inception. We have provided medical and travel insurance to corporations, international travelers, expatriates, students, overseas visitors, immigrants and global citizens for 20 years. Seven Corners Assist, our multilingual 24-hour assistance team, is here to answer questions. You may see any provider of your choice. Contact information for Seven Corners Assist is on your ID card.

*In California, operating under the name Seven Corners Insurance Services.

IMPORTANT BENEFIT HIGHLIGHTS

MEDICAL BENEFITS - If your covered injury or sickness requires medical treatment, we will pay the coverage amounts in the schedule of benefits, minus your chosen per person deductible. Please note that treatment for your injury or sickness must be received within 26 weeks of your injury or sickness.

INTERNATIONAL TRAVEL COVERAGE - If you purchase at least 30 days of coverage, you may travel to countries other than the United States for up to 30 days. This benefit does not include travel back to your home country, and it does not extend after your current expiration date.

EMERGENCY MEDICAL EVACUATION* - We will pay up to $50,000 for an emergency medical evacuation, if your medical condition requires immediate transportation from your current medical facility to the closest facility with appropriate care. This benefit must be ordered by Seven Corners Assist in consultation with your attending Physician. *

DESCRIPTION OF COVERAGE

RETURN OF MORTAL REMAINS* - We will pay up to $7,500 to return your remains to your home country.*

**Arrangements for emergency medical evacuation and repatriation of mortal remains must be made by Seven Corners Assist.*

COMMON CARRIER ACCIDENTAL DEATH & DISMEMBERMENT

This benefit pays up to $25,000 for accidents occurring while you are riding as a passenger in or on any land, water or air conveyance transporting passengers for hire. Your loss must occur within 365 days after the accident date. A description of the covered losses is shown below:

For Loss of:	Indemnity:
Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Either Hand or Foot	One-Half the Principal Sum
Sight of One Eye	One-Half the Principal Sum

Please be aware that this is not a general health insurance policy, but an interim program intended for temporary use. Inbound® Guest does not guarantee payment to a facility or individual for medical expenses until we determine it is an eligible expense.

REFUND OF PREMIUM

We realize there is uncertainty in international travel. Refund of total plan cost will be considered only if a written request is received by Seven Corners prior to your effective date of coverage. If the request is received after your effective date, the unused portion of the plan cost may be refunded minus a cancellation fee, provided you have not submitted a claim.

PRE-EXISTING CONDITIONS

Pre-existing conditions are defined in detail in the policy. A brief summary is shown here.

Pre-existing conditions include any medical condition, sickness, injury, illness, disease, mental illness or mental nervous disorder that existed with reasonable medical certainty during the 180 days before your coverage on Inbound Choice began, whether or not it was previously manifested, symptomatic, known, diagnosed, treated or disclosed. This includes but is not limited to any medical condition, sickness, injury, illness, disease, mental illness or mental nervous disorder for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought treatment during the 180 days before the effective date.

ACUTE ONSET

Non U.S. Citizens traveling in the United States

We pay up to the specified limit for an acute onset of a pre-existing condition *if the condition occurs in the United States during your coverage period, & if* you *receive treatment in the United States within 24 hours of the sudden & unexpected recurrence.* A pre-existing condition that is chronic, congenital or gradually worsens over time is not covered.

SCHEDULE OF BENEFITS & COVERED SERVICES

Age 14 days to Age 69	Plan A	Plan B	Plan C	Plan D	Plan E
INPATIENT	**$25,000 Max per Injury/Sickness**	**$45,000 Max per Injury/Sickness**	**$65,000 Max per Injury/Sickness**	**$85,000 Max per Injury/Sickness**	**$120,000 Max per Injury/Sickness**
Hospital Room & Board Including Laboratory Tests, X-Rays, Prescription Medical and other miscellaneous	Up to $910/day, 30 day max	Up to $1,260/day, 30 day max	Up to $1,565/day, 30 day max	Up to $1,785/day, 30 day max	Up to $2,340/day, 30 day max
Hospital Intensive Care Unit	Add'l $430/day, 8 day max	Add'l $595/day, 8 day max	Add'l $720/day, 8 day max	Add'l $790/day, 8 day max	Add'l $1020/day, 8 day max
Surgical Treatment	Up to $2,150	Up to $2,970	Up to $3,960	Up to $4,840	Up to $6,600
Anesthetist	Up to $540	Up to $740	Up to $990	Up to $1,210	Up to $1,650
Assistant Surgeon	Up to $540	Up to $740	Up to $990	Up to $1,210	Up to $1,650
Physician's Non-Surgical Visits	Up to $40/visit, 1/day, 30 visits max	Up to $50/visit, 1/day, 30 visits max	Up to $65/visit,1/day, 30 visits max	Up to $75/visit, 1/day, 30 visits max	Up to $100/visit, 1/day, 30 visits max
A Consulting Physician, when requested by attending Physician	Up to $295	Up to $405	Up to $465	Up to $485	Up to $600
Private Duty Nurse	Up to $360	Up to $495	Up to $550	Up to $550	Up to $660
Pre-Admission Tests within 7 days before Hospital admission	Up to $715	Up to $990	Up to $1,100	Up to $1,100	Up to $1,100
OUTPATIENT					
Surgical Treatment	Up to $2,150	Up to $2,970	Up to $3,960	Up to $4,840	Up to $6,600
Anesthetist	Up to $540	Up to $740	Up to $990	Up to $1,210	Up to $1,650
Assistant Surgeon	Up to $540	Up to $740	Up to $990	Up to $1,210	Up to $1,650
Physician's Non-Surgical / Urgent Care Visits	Up to $40/visit, 1/day, 10 visits max	Up to $50/visit, 1/day, 10 visits max	Up to $65/visit, 1/day, 10 visits max	Up to $75/visit, 1/day, 10 visits max	Up to $100/visit, 1/day, 10 visits max
Diagnostic X-rays & Lab Services	Up to $295 - Additional $250- One CAT scan, PET scan or MRI	Up to $405 - Additional $250 - One CAT scan, PET scan or MRI	Up to $465 – additional $375 - One CAT scan, PET scan or MRI	Up to $485 - Additional $450 - One CAT scan, PET scan or MRI	Up to $600 - Additional $500 - One CAT scan, PET scan or MRI
Hospital Emergency Room (all expenses incurred therein)	Up to $215	Up to $295	Up to $395	Up to $485	Up to $660
Prescription Drugs	Up to $65	Up to $90	Up to $115	Up to $135	Up to $180
Outpatient Surgical Facility	Up to $650	Up to $900	Up to $1,030	Up to $1,070	Up to $1,320
OTHER TREATMENT & SERVICES					
Ambulance Services	Up to $295	Up to $450	Up to $450	Up to $450	Up to $450
Initial Orthopedic Prosthesis/brace	Up to $715	Up to $990	Up to $1,160	Up to $1,240	Up to $1,560
Chemotherapy and/or radiation therapy	Up to $715	Up to $990	Up to $1,175	Up to $1,275	Up to $1,620
Dental Treatment for Injury to Sound, Natural Teeth	Up to $360	Up to $550	Up to $550	Up to $550	Up to $550
Mental & Nervous Disorder & Substance Abuse	Same as any Sickness	Same as any Sickness	Same as any Sickness	Same as any Sickness	Same as any Sickness
Physiotherapy	Up to $30/visit, 1/day, 12 visits max	Up to $40/visit, 1/day, 12 visits max	Up to $40/visit, 1/day, 12 visits max	Up to $40/visit, 1/day, 12 visits max	Up to $40/visit, 1/day, 12 visits max
Acute Onset of Pre-existing Condition(s)	$25,000 *per policy period* for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & $25,000 *per policy period* for Emergency Medical Evacuation.	$45,000 *per policy period* for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & $25,000 *per policy period* for Emergency Medical Evacuation.	$65,000 *per policy period* for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & $25,000 *per policy period* for Emergency Medical Evacuation.	$85,000 *per policy period* for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & $25,000 *per policy period* for Emergency Medical Evacuation.	$120,000 *per policy period* for Medical Expense Benefits (subject to the sublimits for each benefit shown above) & $25,000 *per policy period* for Emergency Medical Evacuation.

If you turn 70 years old during the purchased coverage period, the 70 and over benefit schedule becomes effective on the day you turn 70. If you have the $100,000 or $130,000 per injury or sickness policy maximum, you will receive the $70,000 per injury or sickness schedule for age 70 and older. If you have the $75,000 or $50,000 per injury or sickness policy maximum, you will receive the $50,000 per injury or sickness schedule for age 70 and older.

SCHEDULE OF BENEFITS & COVERED SERVICES (CONT.)

Age 70 to Age 99	Plan J	Plan K	Plan L
INPATIENT	**$40,000 Max per Injury/Sickness**	**$60,000 Max per Injury/Sickness**	**$100,000 Max per Injury/Sickness**
Hospital Room & Board including miscellaneous	Up to $870/day, 30 day max	Up to $1,260/day, 30 day max	Up to $2,050/day, 30 day max
Hospital Intensive Care Unit	Additional $380/day, 8 day max	Additional $550/day, 8 day max	Additional $900/day, 8 day max
Surgical Treatment	Up to $2,285	Up to $3,300	Up to $5,365
Anesthetist	Up to $570	Up to $825	Up to $1,340
Assistant Surgeon	Up to $570	Up to $825	Up to $1,340
Physician's Non-Surgical Visits	Up to $45/visit, 1/day, 30 visits max	Up to $65/visit, 1/day, 30 visits max	Up to $100/visit, 1/day, 30 visits max
A Consulting Physician, when requested by attending Physician	Up to $330	Up to $480	Up to $780
Private Duty Nurse	Up to $375	Up to $450	Up to $880
Pre-Admission Tests w/in 7 days before Hospital admission	Up to $775	Up to $775	Up to $1,500
OUTPATIENT			
Surgical Treatment	Up to $2,285	Up to $3,300	Up to $5,365
Anesthetist	Up to $570	Up to $825	Up to $1,340
Assistant Surgeon	Up to $570	Up to $825	Up to $1,340
Physician's Non-Surgical / Urgent Care Visits	Up to $45/visit, 1/day, 10 visits max	Up to $65/visit, 1/day, 10 visits max	Up to $100/visit, 1/day, 10 visits max
Diagnostic X-rays & Lab Services	Up to $330 - Additional $250 - One CAT scan, PET scan or MRI	Up to $480 – additional $300 - One CAT scan, PET scan or MRI	Up to $780 – additional $300 - One CAT scan, PET scan or MRI
Hospital Emergency Room (all expenses incurred therein)	Up to$208	Up to $300	Up to $480
Prescription Drugs	Up to $65	Up to $95	Up to $160
Outpatient Surgical Facility	Up to $705	Up to $1,020	Up to $1,660
OTHER TREATMENT AND SERVICES			
Ambulance Services	Up to $450	Up to $450	Up to $880
Initial Orthopedic Prosthesis/brace	Up to $705	Up to $1,020	Up to $1,660
Chemotherapy and/or radiation therapy	Up to $705	Up to $1,020	Up to $1,660
Dental Treatment for Injury to Sound, Natural Teeth	Up to $550	Up to $550	Up to $1,075
Mental & Nervous Disorder & Substance Abuse	Same as any Sickness	Same as any Sickness	Same as any Sickness
Physiotherapy	Up to $40/visit, 1/day, 12 visits max	Up to $40/visit, 1/day, 12 visits max	Up to $80/visit, 1/day, 12 visits max
Accute Onset of Pre-existing Conditions	This benefit is not available if you are 70 or older	This benefit is not available if you are 70 or older	This benefit is not available if you are 70 or older

IMPORTANT INFORMATION

The information concerning Inbound® Guest is not intended to be an offer to sell Inbound® Guest or a solicitation by Seven Corners, Inc. or Lloyd's of London in any jurisdiction where any such sale would be unlawful or in which Seven Corners or Lloyd's of London are not qualified to do so.

PROOF OF YOUR COVERAGE - When you purchase coverage on Inbound® Guest, you will receive an email from Seven Corners. This will include your virtual ID card and a link to the program summary. This is the legal document which describes the benefits and provisions of the plan in detail.

CLAIM SUBMIISSION - Filing a claim with us is easy. When you receive treatment, send the itemized bills to Seven Corners within 90 days via e-mail, fax, or postal mail along with a completed Proof of Loss form (available online). Contact information is provided in your program summary. Please retain your original bills should there be a need for verification. Eligible bills are automatically converted from local currencies to U.S. dollars. For more details, contact the Seven Corners Claim Department.

This specifically includes but is not limited to any medical condition, sickness, injury, illness, disease, mental illness or mental nervous disorder, for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought treatment during the 180 days (365 days if 70 & older) immediately preceding your effective date of coverage.

ACUTE ONSET OF A PRE-EXISTING CONDITION means a sudden and unexpected outbreak or recurrence of a pre-existing condition which occurs spontaneously and without advance warning either in the form of physician recommendations or symptoms and is of short duration, is rapidly progressive, and requires urgent care. The acute onset must occur after the effective date of the policy, and treatment must be obtained within 24 hours of the sudden and unexpected outbreak or recurrence. A pre-existing condition that is a chronic or congenital condition or that gradually becomes worse over time will not be considered an acute onset. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs or treatment existent or necessary prior to your effective date of coverage.

HOME COUNTRY- means the country where you have your true, fixed and permanent home and principal establishment.

EXCLUSIONS AND LIMITATIONS

The list below is a summary of the exclusions in the certificate. This brochure is intended as a brief summary of benefits and services and is not your policy. A complete description of the provisions, benefits, and exclusions are contained in the certificate of coverage which will be provided to you after your coverage has been issued. A sample of the certificate is provided online. If there is any difference between this brochure and your certificate of coverage, the provisions of the certificate will prevail.

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

- Pre-existing Conditions. If you are a non-U.S. citizen under age 70, this exclusion is waived for an Acute Onset of a Pre-existing Condition (defined above) as shown in the schedule of benefits for your plan (A, B, C, D, or E). Benefits will be provided for expenses incurred in the U.S., minus your deductible and subject to the scheduled limits. All other exclusions apply.
- Travel solely for medical treatment; travel against a Physician's advice; expenses which are not medically necessary;
- Expenses incurred in your home country or country of regular domicile;
- Routine physicals, inoculations, well-baby care & nursery, new-born baby care; related Physician charges;
- Eye exams & treatment of visual defects; glasses; contact lenses;
- Hearing exams, hearing aids; treatment for hearing defects;
- Dental treatment, unless due to injury to sound, natural teeth;
- Services or supplies provided by a family member or anyone living with you;
- Weak, strained or flat feet, corns, calluses, or toenails;
- Cosmetic surgery, treatment for congenital anomalies *(except as specifically provided)*, except reconstructive surgery due to a covered injury or sickness;
- Elective surgery & elective treatment;
- Treatment to promote conception or prevent conception & childbirth;
- Injury while participating in professional, sponsored &/or organized amateur or interscholastic athletics;
- Organ transplants;
- Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with war, invasion, act of foreign enemy hostilities, warlike operations *(whether war be declared or not)*, or civil war; terrorist activity; nuclear, chemical or biological weapons; (*details in program summary)*;
- Participation in a riot or civil disorder, commission of or attempt to commit a felony;
- Suicide or attempted suicide *(including drug overdose)* while sane or insane*;* intentionally self-inflicted Injury;
- Expenses of an institution, health service, or infirmary which does not require payment in the absence of insurance;
- Treatment of nervous or mental disorders, except as stated in the schedule of benefits; treatment of alcoholism or drug abuse, except as provided for treatment of mental/nervous disorders, according to the schedule of benefits;
- Loss from riding in any aircraft, other than as a passenger in an aircraft licensed for the transportation of passengers;
- Treatment, services, or supplies in a hospital owned/operated by: a)The Veteran's Administration; or b) A national government or its agencies. *(This exclusion does not apply to treatment you are required by aw to pay)*;
- Duplicate services of a certified nurse-midwife and Physician;
- A hospital emergency room visit not of an emergency nature;
- Outpatient treatment for the detection or correction by manual or mechanical means of structural imbalance, distortion or sublimation in the human body for purposes of removing nerve interference & the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;
- Injury while taking part in mountaineering where ropes or guides are normally used, hang gliding, parachuting, bungee jumping, racing by horse or motor vehicle or motorcycle, motorcycle/motor scooter riding, scuba diving involving underwater breathing apparatus *(unless PADI or NAUI certified)*, water skiing, snow skiing, snow boarding and snowmobiling;
- Treatment paid for or furnished under any other individual, government, or group policy; previous policy; Worker's Compensation or Occupational Disease Law or Act; charges provided at no cost to you;
- Expense incurred after your expiration date except as may be specifically provided;
- Treatment for alcohol & drug addiction; use of drugs or narcotic agents; injury/ sickness due to the effects of intoxicating liquor or drugs, unless prescribed by a physician;
- Sexually transmitted diseases;
- Pregnancy expenses or sickness resulting from pregnancy, childbirth, or miscarriage; or for miscarriage resulting from injury; or voluntary or elective abortion;
- Custodial care, educational or rehabilitative care & nursing services in a long term facility, spa, hydroclinic, weight loss clinic, sanatorium, nursing home or similar facilities;
- Speech therapy, occupational therapy, vocational rehabilitation;
- Treatment if you are HIV Positive at the time of application for this insurance, whether or not you were asymptomatic or symptomatic or had knowledge of your HIV status on your effective date or any associated diagnostic tests or charges for HIV infection, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS, & all diseases caused by &/or related to HIV;
- Treatment for HIV, the AIDS virus, AIDS related illnesses, ARC Syndrome, AIDS, & all diseases caused by &/or related to HIV or complications from these conditions, including the cost of testing for these conditions &/or charges for treatment.

EXCLUSIONS AND LIMITATIONS

PLAN COST

Rates Effective July 1, 2014

$0 Per Injury/Sickness Deductible Per Person
Policy Maximum Options

	Plan A	Plan B	Plan C	Plan D	Plan E
Age	**$25,000**	**$45,000**	**$65,000**	**$85,000**	**$120,000**
	Daily Rate	*Daily Rate*	*Daily Rate*	*Daily Rate*	*Daily Rate*
2 weeks -18	$0.77	$1.36	$1.67	$1.88	$2.44
19 to 29	$0.77	$1.09	$1.31	$1.54	$1.96
30 to 39	$0.87	$1.26	$1.51	$1.72	$2.20
40 to 49	$0.90	$1.31	$1.63	$1.82	$2.41
50 – 59	$1.27	$1.83	$2.20	$2.50	$3.20
60 - 69	$1.47	$2.01	$2.45	$2.78	$3.60
Dependent Child*	$0.80	$1.29	$1.59	$1.79	$2.32

$50 Per Injury/Sickness Deductible Per Person
Policy Maximum Options

	Plan A	Plan B	Plan C	Plan D	Plan E
Age	**$25,000**	**$45,000**	**$65,000**	**$85,000**	**$120,000**
	Daily Rate	*Daily Rate*	*Daily Rate*	*Daily Rate*	*Daily Rate*
2 weeks - 18	$0.65	$1.13	$1.39	$1.56	$2.03
19 to 29	$0.65	$0.94	$1.09	$1.24	$1.63
30 to 39	$0.73	$1.05	$1.24	$1.42	$1.82
40 to 49	$0.78	$1.12	$1.32	$1.49	$1.90
50 –59	$1.02	$1.55	$1.84	$2.02	$2.69
60 – 69	$1.26	$1.72	$2.02	$2.27	$2.99
Dependent Child*	$0.78	$1.07	$1.32	$1.48	$1.93

$100 Per Injury/Sickness Deductible Per Person
Policy Maximum Options

	Plan A	Plan B	Plan C	Plan D	Plan E
Age	**$25,000**	**$45,000**	**$65,000**	**$85,000**	**$120,000**
	Daily Rate	*Daily Rate*	*Daily Rate*	*Daily Rate*	*Daily Rate*
2 weeks – 18	$0.56	$1.05	$1.29	$1.45	$1.89
19 to 29	$0.56	$0.82	$0.97	$1.20	$1.54
30 to 39	$0.66	$0.95	$1.15	$1.33	$1.71
40 to 49	$0.68	$1.00	$1.26	$1.41	$1.85
50 – 59	$0.96	$1.39	$1.74	$1.94	$2.63
60 – 69	$1.16	$1.54	$1.89	$2.13	$2.92
Dependent Child*	$0.72	$1.00	$1.23	$1.38	$1.80

* Dependent Child rate (Ages 2 weeks to 18) is applicable when at least one parent will also be covered under Inbound® Guest.

Monthly/ Daily Premiums for Ages 70 and Older

$100 Per Injury/Sickness Deductible Per Person
Policy Maximum Options

	Plan J	Plan K	Plan L
Age	**$40,000**	**$60,000**	**$100,000**
	Daily Rate	*Daily Rate*	*Daily Rate*
Age 70 – 74	$2.47	$3.58	$5.81
Age 75 – 79	$2.72	$3.94	$6.40
Age 80 – 84	$5.48	$7.92	$12.87
Age 85 – 89	$7.90	$11.42	$18.56
Age 90 – 94	$8.55	$12.36	$20.09
Age 95 – 99	$9.83	$14.21	$23.09

$200 Per Injury/Sickness Deductible Per Person
Policy Maximum Options

	Plan J	Plan K	Plan L
Age	**$40,000**	**$60,000**	**$100,000**
	Daily Rate	*Daily Rate*	*Daily Rate*
Age 70 – 74	$2.06	$2.98	$4.84
Age 75 – 79	$2.27	$3.28	$5.32
Age 80 – 84	$4.57	$6.61	$10.74
Age 85 – 89	$6.73	$9.73	$15.81
Age 90 – 94	$7.29	$10.54	$17.12
Age 95 – 99	$8.37	$12.10	$19.66

INBOUND® GUEST APPLICATION

[pull-out application form]

Effective July 1, 2014

(please print or type using black ink)

Official Use Only:

Cert#: Processed: Eff. Date: Agent: 11219

APPLICANT INFORMATION

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms

Last Name: _____

First Name: _____ M.I. _____

Country of Permanent, fixed Residence (Home Country) _____

Passport Number: _____

for accidental death & dismemberment benefit

Beneficiary: _____ Relationship: _____

us address of correspondence (address must be in the United States)

Name: _____

Address: _____

City: _____ State: _____

Postal Code: _____ Country: _____

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

Email Address: _____

When did or will you arrive in the United States: ____/____/____ *(MM/DD/YY)*

Date you would like coverage to begin: ____/____/____ *(MM/DD/YY)*

Date you would like coverage to end: ____/____/____ *(MM/DD/YY)*

Note: This program is not available to United States citizens. Your coverage must begin within 6 months of your arrival in the United States. The minimum period of coverage is 5 days, maximum is 180 days. Coverage cannot begin until you depart from your Home Country and Seven Corners both receives and accepts your application and correct premium.

coverage specifics

Have you purchased insurance through Seven Corners before? ❑ No ❑ Yes

If Yes, ID Number: _____

Age 2 weeks to Age 69:

❑ Plan A: $25,000
❑ Plan B: $45,000
❑ Plan C: $65,000
❑ Plan D: $85,000
❑ Plan E: $120000

Age 70 to 99:

❑ Plan J: $40,000
❑ Plan K: $60,000
❑ Plan L: $100,000

Selected Per Injury/Sickness Deductible:

❑ $0 ❑ $50 ❑ $100 ❑ $200

If there are applicants below age 70 and applicants age 70 and above, separate applications must be submitted.

Complete and return the Application with payment made payable to:
World Commercial Trust
P.O. Box: 56575, Station A
Toronto, ON M5W 4L1

(You may fax your application only if paying by credit card. Originals are not required if application is faxed to Seven Corners with credit card payment.)

Attention Applicants: *Certain Underwriters at Lloyd's of London, operates as an approved Surplus Lines market in the United States. The premiums listed include a general Surplus Lines Tax. Your State of Residence may warrant an additional Surplus Lines Tax, Stamping Fees and administration fee. Upon receipt and review of your application, Seven Corners will inform you if additional taxes and fees apply. If so, Seven Corners will request the payment of the additional taxes and fees from you prior to issuing coverage. The additional Surplus Lines Taxes and fees will be listed on the declaration page of your policy.*

calculating your plan cost *(please complete entire section)*

	Date of Birth (MM/DD/YY)	Daily Rates
Applicant: _____	(__/__/__)	_____
Spouse: _____	(__/__/__)	_____
Child: _____	(__/__/__)	_____
Child: _____	(__/__/__)	_____
Child: _____	(__/__/__)	_____
	Daily Total $	_____
Multiply Daily Rate Total by number of days:	x	_____
Total Payment Enclosed (Total)		_____

method of payment

❑ Check ❑ Money Order ❑ MasterCard ❑ Credit/Debit

❑ Visa ❑ Discover ❑ American Express

Card Number: _____

Expiration Date: _____ Daytime Phone: ( ) _____

Name as it appears on Card: _____

Signature *(Required)* _____

Billing Address: _____

Please make check or money order payable to "World Commercial Trust." Total payment for the full term of your coverage must be paid in U.S. dollars (checks must be issued from a U.S. bank) at the time you apply. Purchase by credit card is subject to validation & acceptance by the credit card company. I declare that I understand the terms and conditions of this product. I understand that pre-existing conditions, as defined, are excluded, unless otherwise specifically noted as covered in the policy. I understand this program is for persons traveling outside their home country.

I hereby subscribe to the World Commercial Trust and enroll in the group coverage for which I am eligible under the group contract issued by Certain Underwriters at Lloyd's of London and the group contract issued by Tramont Insurance Company Limited.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I declare that I have read & understand the terms & conditions of this product. Whenever coverage provided by this policy would be in violation of U.S or appropriate state law, including U.S. economic or trade sanctions, such coverage will be null & void.

Patient Protection and Affordable Care Act: This insurance is not subject to, and does not provide certain insurance benefits required by the United States Patient Protection and Affordable Care Act ("PPACA"). The insurance benefits provided by this policy are stated in your policy documents and do not include additional benefits required by PPACA. The PPACA requires certain U.S. residents and citizens to obtain PPACA compliant insurance coverage. In certain circumstances penalties may be imposed on U.S. residents and citizens who do not maintain PPACA compliant insurance coverage. You should consult your attorney, insurance agent or tax professional to determine if the PPACA's requirements are applicable to you.

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Signature of Insured or Proxy *(Required)* Date

inbound® guest

ADMINISTERED BY

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INSURANCE CARRIER

Inbound® USA is underwritten by Certain Underwriters at Lloyd's of London, rated "A" (Excellent) by A.M. Best and "A+" (Strong) by Standard & Poor's.

This brochure is intended as a brief summary of benefits and services. It is not your policy. If there is any difference between this brochure and your policy, the provisions of the policy will prevail. Benefits and premiums are subject to change.

FOR ADDITIONAL INFORMATION

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