HealthCare International Premiums

For Policies with Effective Dates
through December 31, 2017

Age of Applicant	Persons to be Insured	Monthly Premiums Area A	Area B	Area C
0–25	Adult	$ 110	$ 145	$ 225
26–39	Adult	$ 125	$ 160	$ 260
40–54	Adult	$ 170	$ 200	$ 330
55–70	Adult	$ 300	$ 435	$ 575
	Dependent Child	$ 75	$ 90	$ 150

Definition of Dependent Child
Unmarried child declared on the Application, between 15 days and under 20 years of age, traveling or residing with their parent(s) outside their home country.

Optional: $100,000 Accidental Death & Dismemberment Benefit: $25 per month (Available only for persons age 18 or older)

The premium calculation is based upon the Applicant's age, destination area (A, B or C) and the length of time to be insured. The minimum renewal premium is three (3) times Monthly Premium even if less than three months of insurance is requested.

Area A includes those countries within Europe, Central America, South America and elsewhere in the world not specifically named under Areas B and C.

Area B includes Africa (every country located on the continent of Africa and the islands of Madagascar and the Seychelles; Russia and the Newly Independent States (formerly the USSR); Middle East and Asia.

Area C includes the United States (its possessions and territories), Canada, the Caribbean Islands and Bermuda.

Please see the Definitions and Administration for more precise details on the countries included within Areas A, B and C.

If you are traveling to more than one area or to an area where civil unrest exists, please call the Administrator for the appropriate premium.

Administered by:

Wallach & COMPANY, INC.

*"Smart" insurance for informed travelers.*SM

107 West Federal Street
Post Office Box 480
Middleburg, Virginia 20118-0480 USA
Telephone:
(800) 237-6615 or (540) 687-3166
Fax: (540) 687-3172
Email: info@wallach.com www.wallach.com

12/16

HealthCare International

RENEWAL APPLICATION

HealthCare International RENEWAL APPLICATION

Applicant

Name

Birth Date

Address

Email Address

Nationality Passport No.

Purpose of Travel

Destination Country(ies)

Name of Emergency Contact in Home Country Relationship

Telephone Number of Emergency Contact in Home Country

Information on Spouse/Family

(if they are to be insured)

Spouse (Name)
Sex: ☐ M ☐ F Birth Date

Child (Name)
Sex: ☐ M ☐ F Birth Date

Child (Name)
Sex: ☐ M ☐ F Birth Date

Child (Name)
Sex: ☐ M ☐ F Birth Date

Application and all correspondence should be mailed or faxed to:
Wallach & Company, Inc.
107 West Federal Street
Post Office Box 480
Middleburg, Virginia 20118-0480 USA
Fax: (540) 687-3172

Premium Calculation

(see monthly premiums on back of this application)

$ _____ Monthly Premium

\+ $ _____ Optional Monthly AD&D Premium

Name of AD&D Beneficiary

= $ _____ Total Monthly Premium

X _____ Number of Months Requested (12 month maximum)

= $ _____ Total Policy Premium

The minimum renewal policy premium is three (3) times the total monthly premium, even if less than three months of insurance is requested.

Requested Effective Date

The effective date of the insurance cannot be prior to the date this Application and premium are received and approved by the Administrator.

Payment

☐ Check/Money Order payable in U.S. funds, drawn on a U.S. bank, and made payable to **Wallach & Company, Inc.**

☐ VISA ☐ American Express ☐ MasterCard

Card Number

Name on Credit Card

Expiration Date

Signature

Declaration of Applicant

Have you or your dependents submitted or plan to submit any claims for medical expenses which were incurred prior to the renewal of this insurance? ☐ Yes ☐ No

I declare that the information given in this Application is true and complete. I understand (on behalf of the person(s) to be insured) that this insurance will not cover treatment arising from any diseases, injuries or medical conditions known to exist within the one year period immediately prior to the original effective date of this insurance. It is agreed that this declaration and the information given herein shall form the basis of the contract between the Insured Person and the Company.

Signature of Applicant

Date

12/16