PATRIOT T.R.I.P.® STUDENT GROUP APPLICATION

1. Complete this entire Application.
2. If paying by check or money order, please make payable to iTravelInsured and enclose in envelope with signed Application.
3. Mail or fax completed Application to: iTravelInsured, P.O. Box 88503, Indianapolis, Indiana 46208-0503 USA Fax 317-655-4505.

Date of Departure_____________________ **Date of Return**_____________________

**Note: Patriot T.R.I.P. Student is designed for trips of 30 days or less, the trip cost is subject to a $300 minimum and coverage is available up to $5,000. This plan is offered only to students who are 25 years of age or younger during the covered trip.*

Contact Information (please print) ❑ **Mr.** ❑ **Mrs.** ❑ **Ms.**

Name (First)________________________ (Last)____________________________

Name of School, Camp or Group, if applicable:

____

Address____

City, State, Country, Zip______________________________________

Email address____

Phone____

Name of traveler (last, first)	Birth Year	Country of Citizehship	Program Cost Calculation		Cost
			______ - ______ = ______ Current year Birth year Total years	$______ X .0253 = Cost of trip Rate factor	
			______ - ______ = ______ Current year Birth year Total years	$______ X .0253 = Cost of trip Rate factor	
			______ - ______ = ______ Current year Birth year Total years	$______ X .0253 = Cost of trip Rate factor	
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			______ - ______ = ______ Current year Birth year Total years	$______ X .0253 = Cost of trip Rate factor	

MEMBERSHIP I (we) hereby apply for membership to the National Small Business Travel and Health Association.

CERTIFICATION I (we) hereby certify and represent that I (we) have read, or have had read to me (us), all statements and answers recorded on this application. They are true, complete and correctly recorded. I (we) confirm that all travelers listed on this application are medically able to travel on the date this coverage is purchased. I (we) understand and agree that subject to the acceptance of this application and payment of the program cost in full, coverage will begin at 12:01 a.m. on the day after this completed application is received.

***X* Signature of Applicant or Proxy**_________________________________

Date____________________ Phone____________________________________

Payment Method ❑ Check (To iTravelInsured)
❑ Money Order (To iTravelInsured) ❑ Mastercard ❑ Visa
❑ American Express ❑ JCB ❑ Discover

If paying by credit card, I authorize iTravelInsured to debit my credit card account for the total charge as specified in Total Program Cost. Coverage purchased by credit card is subject to validation and acceptance by credit card company. I agree to comply with the cardholder agreement.

Card#____________________________Expiration date__________

Name on Card____

Signature____

Your Daytime Phone_______________________________________

Your Billing Address______________________________________

____

Total Program Cost

Producer# 10550
GA#________
Name________
Address 301 EAST 66 ST[redacted]EET,
City, State, Zip NEW YORK NY 10065
Phone: 617-964-4849