Dallas, Texas
Administrative Office: 399 Park Avenue, 8th Floor, New York, NY 10022

BLANKET TRAVEL APPLICATION

Application is hereby made for Blanket Travel Accident Insurance.

1. Name of Policyholder:____

2. Mailing Address:____
Street City State Zip

3. Requested Policy Effective Date:______________

4. Requested Policy Term:______________________

5. Covered Trips: *(Please describe the trip(s) contemplated, including departure city, destination city, departure date, and return date.)*

____
____

6. Purpose of Trip: *(Please describe the reason for the trip and provide any schedule of events.)*

____
____

7. Classes of Eligible Persons: *(Please identify the Classes of Eligible Persons who will be traveling.)*

____
____

8. Number of Covered Persons by Age & Gender

____
____

9. Policy Benefits: *(Please check one or both Policy Benefits)*

___ Accidental Death & Dismemberment Benefit
Principal Sum: $__________ per Covered Person
Time Period for Loss from date of Covered Accident: _____ days

___ Accident-Only Medical Expense Benefit
Part A. If the Covered Person IS covered under a Comprehensive Health Benefit Plan:
Benefit Maximum: $__________ per Covered Person per ***Covered Accident*** or ***Policy Term***
Maximum Benefit Period: ______________________________

Part B. If the Covered Person IS NOT covered by a Comprehensive Health Benefit Plan:
Benefit Maximum: $__________ per Covered Person per ***Covered Accident*** or ***Policy Term***
Deductible: $_______ per Covered Person per ***Covered Accident*** or ***Policy Term***
Co-insurance Rate: ______% of Usual & Customary Charges
Maximum Benefit Period: ______________________________

10. Optional Riders: *(Please check each Rider desired)*
Note: Each Optional Rider's Benefit Amount, Benefit Maximum and Deductible is per Covered Person.

___ <u>Emergency Sickness Benefit Rider</u> *(Applies Only While on a Covered Trip Outside of the U.S.)*
Emergency Sickness Medical Expense Benefit *(An expansion of the Policy's Accident-Only Medical Expense Benefit. Any benefits paid for this benefit will be applied to the applicable Benefit Maximum shown above.)*

___ <u>Emergency Medical Evacuation Benefit Rider</u>
Benefit Maximum: $___________ Deductible: $________ per ***Covered Accident*** or ***Policy Term***

___ <u>Repatriation of Remains Benefit Rider</u>
Benefit Maximum: $___________ Deductible: $________ per ***Covered Accident*** or ***Policy Term***

___ <u>Political Evacuation Benefit Rider</u> (*Applies Only While on a Covered Trip Outside of the U.S.)*
Benefit Maximum: $___________ Deductible: $________ per ***Covered Trip*** or ***Policy Term***

___ <u>Coma Benefit Rider</u>
Waiting Period: _____ days after Covered Accident Benefit Maximum: $___________

___ <u>Emergency Reunion Benefit Rider</u>
Benefit Maximum: $___________ Deductible: $________ per ***Covered Accident*** or ***Policy Term***

___ <u>Permanent Total Disability Benefit Rider</u>
Disability Commencement Period: _____ days after Covered Accident
Qualification Period: ______ weeks Lump Sum Benefit Amount: $___________

___ <u>Trip Interruption Benefit Rider</u>
Benefit Maximum: $___________ Deductible: $________ per ***Covered Accident*** or ***Policy Term***

___ <u>Felonious Assault / Serious Crime Benefit Rider</u>
Benefit Amount: $____________

___ <u>Bereavement and Trauma Counseling Benefit Rider</u>
Benefit Amount Per Session: _____% of U&C Charges Maximum Number of Sessions: _____
Benefit Period: _____ years after Covered Accident Benefit Maximum: $___________

___ <u>Home Alteration & Vehicle Modification Benefit Rider</u>
Benefit Maximum: $___________

___ <u>Terrorism Risk Coverage Rider</u>
Requested Countries: ____

___ <u>War Risk Coverage Rider</u>
Requested Countries: ____

11. Aggregate Limit Benefit Maximum: $_____________ per Covered Accident

The statements made herein are true and complete to the best of my knowledge, and it is understood and agreed that the insurance shall not become effective unless this Master Application and Effective Date are approved in writing by Starr Indemnity & Liability Company. All statements made by the Policyholder in this Master Application will be deemed representations and not warranties.

WARNING: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

____________________________________	____________________________________
Date	Date
____________________________________	____________________________________
Authorized Signature	Licensed Agent's Signature
____________________________________	____________________________________

Officer's Name	Licensed Agent's Name
Title	Licensed Agent ID#