109 S. 13th Street, Suite 117B, Philadelphia, PA 19107

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.

___ Emergency Sickness Benefit Rider *(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.)*

___ Emergency Medical Evacuation Benefit Rider
Benefit Maximum: $_____ Deductible: $_____ per ***Covered Accident*** or ***Policy Term***

___ Repatriation of Remains Benefit Rider
Benefit Maximum: $_____ Deductible: $_____ per ***Covered Accident*** or ***Policy Term***

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

___ Coma Benefit Rider
Waiting Period: _____ days after Covered Accident Benefit Maximum: $_____

___ Emergency Reunion Benefit Rider
Benefit Maximum: $_____ Deductible: $_____ per ***Covered Accident*** or ***Policy Term***

___ Permanent Total Disability Benefit Rider
Disability Commencement Period: _____ days after Covered Accident
Qualification Period: _____ weeks Lump Sum Benefit Amount: $_____

___ Trip Interruption Benefit Rider
Benefit Maximum: $_____ Deductible: $_____ per ***Covered Accident*** or ***Policy Term***

___ Felonious Assault / Serious Crime Benefit Rider
Benefit Amount: $_____

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

___ Home Alteration & Vehicle Modification Benefit Rider
Benefit Maximum: $_____

___ Terrorism Risk Coverage Rider

Requested Countries: _____

___ War Risk Coverage Rider
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 Gagliardi Insurance Services, Inc. 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#