



**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

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Officer's Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Licensed Agent's Signature

\_\_\_\_\_  
Licensed Agent's Name

\_\_\_\_\_  
Licensed Agent ID#