



TRAWICK
INTERNATIONAL



SAFE TRAVELS FOR VISITORS TO THE USA

- > Scheduled Benefits Accident and Sickness Medical Coverage
- > Emergency Medical Evacuation and Repatriation
- > For persons traveling to North America from other countries
- > Available for ages 14 days to 89 years
- > A minimum period of 5 days up to a maximum period of 364 days
- > Renewable for up to one year



MEDICAL SCHEDULE OF BENEFITS

AGE 14 DAYS TO AGE 69	BASIC	SILVER	GOLD	PLATINUM	DIAMOND Ages 50 to 89
Policy Maximums	\$50,000 Max per Injury/Sickness	\$75,000 Max per Injury/Sickness	\$100,000 Max per Injury/Sickness	\$175,000 Max per Injury/Sickness	\$50,000 Annual Policy Max
Deductible options (per Incidence)	\$0, \$50 \$100				\$100 or \$200

INPATIENT

Hospital Room & Board including Laboratory Tests, X-Rays, Prescription Medical and other miscellaneous	Up to \$1400/day, 30 day max	Up to \$1750/day, 30 day max	Up to \$2000/day, 30 day max	Up to \$2700/day, 30 day max	Up to \$1500 /day, 15 day max
Hospital Intensive Care Unit	Additional \$700/day, 8 day Max	Additional \$800/day, 8 day Max	Additional \$900/day, 8 day Max	Additional \$1150/day, 10 day Max	Additional \$500/day, 8 day Max
Surgical Treatment	Up to \$3500	Up to \$4750	Up to \$6000	Up to \$7500	Up to \$3500
Anesthetist	Up to \$850	Up to \$1200	Up to \$1400	Up to \$1800	Up to \$850
Assistant Surgeon	Up to \$850	Up to \$1200	Up to \$1400	Up to \$1800	Up to \$850
Physician's Non-Surgical Visits	Up to \$55/visit, 1/day, 30 visits Max	Up to \$70/visit, 1/day, 30 visits Max	Up to \$85/visit, 1/day, 30 visits Max	Up to \$115/visit, 1/day, 30 visits Max	Up to \$55/visit, 1/day, 30 visits Max
A Consulting Physician, when requested by attending Physician	Up to \$450	Up to \$550	Up to \$550	Up to \$700	Up to \$450
Private Duty Nurse	Up to \$450	Up to \$550	Up to \$550	Up to \$700	Up to \$450
Pre-Admission Tests w/in 7 days before admission	Up to \$1100	Up to \$1100	Up to \$1200	Up to \$1500	Up to \$1100

OUTPATIENT

Surgical Treatment	Up to \$3500	Up to \$4750	Up to \$6000	Up to \$7500	Up to \$3000
Anesthetist	Up to \$850	Up to \$1200	Up to \$1400	Up to \$1800	Up to \$700
Assistant Surgeon	Up to \$850	Up to \$1200	Up to \$1400	Up to \$1800	Up to \$700
Physician's Visits/ Urgent Care	Up to \$55/visit, 1/day, 30 visits Max	Up to \$70/visit, 1/day, 30 visits Max	Up to \$85/visit, 1/day, 30 visits Max	Up to \$115/visit, 1/day, 30 visits Max	Up to \$55/visit, 1/day, 30 visits Max
Diagnostic X-rays & Lab Services	\$450	\$475	\$500	\$675	\$450
Scans, PET scan or MRI	Up to \$650 Scan PET scan or MRI	\$875 scan, PET scan or MRI	Up to \$1050 scan, PET scan or MRI	Up to \$1300 Scan, PET scan or MRI	Up to \$650 Scan PET scan or MRI
Hospital Emergency Room (all expenses incurred therein)	Up to \$350	Up to \$450	Up to \$550	Up to \$800	Up to \$350
Prescription Drugs (outpatient) Per Sickness/ Injury	Up to \$100	Up to \$125	Up to \$150	Up to \$200	Up to \$90
Outpatient Surgical Facility	Up to \$1000	Up to \$1150	Up to \$1275	Up to \$1400	Up to \$1000
Physical Therapy	Up to \$40/visit, 1/day, 12 visits Max	Up to \$40/visit, 1/day, 12 visits Max	Up to \$40/visit, 1/day, 12 visits Max	Up to \$60/visit, 1/day, 12 visits Max	Up to \$40/visit, 1/day, 12 visits Max

MEDICAL SCHEDULE OF BENEFITS

OTHER TREATMENT AND SERVICES					
Ambulance Services	Up to \$500	Up to \$500	Up to \$500	Up to \$750	Up to \$500
Initial Orthopedic Prosthesis/brace	Up to \$1100	Up to \$1225	Up to \$1350	Up to \$1750	Up to \$1100
Chemotherapy &/ or radiation therapy	Up to \$1100	Up to \$1225	Up to \$1350	Up to \$1750	Up to \$1100
Dental Treatment for Injury to Sound, Natural Teeth	Up to \$600	Up to \$600	Up to \$600	Up to \$600	Up to \$600
Mental & Nervous Disorder & Substance Abuse	Up to \$5000	Up to \$5000	Up to \$5000	Up to \$20,000 30 days Max	Up to \$5000
Emergency Medical Evacuation*	\$100,000	\$100,000	Unlimited	Unlimited	\$50,000
Repatriation of Remains*	\$7,500	\$10,000	\$20,000	\$25,000	\$7,500
Natural Disaster, Political Evacuation & Repatriation*	Up to \$500	Up to \$1,000	Up to \$1,500	Up to \$2,000	Up to \$500
Return of Minor Children or Grand-Children*	Up to \$5,000	Up to \$7,500	Up to \$7,500	Up to \$10,000	Up to \$5,000
Felonious Assault AD&D*	Up to \$5,000	Up to \$7,500	Up to \$7,500	Up to \$10,000	Up to \$5,000
Return to Home Coverage*	Up to 30 days per 12 months Max \$2000	Up to 60 days per 12 months Max \$2500	Up to 60 days per 12 months Max \$5000	Up to 90 days per 12 months Max \$7,500	N/A
AD&D Principal Sum*	\$25,000 Common Carrier	\$35,000 Common Carrier	\$35,000 Common Carrier	\$35,000 Common Carrier	N/A
Acute Onset of Pre-existing Condition(s) per policy period for Medical Expense Benefits and Emergency Medical Evacuation; Subject to the sub limits for each benefit listed	Up to the Maximum policy limit per Period of Coverage; Maximum Lifetime Limit for Emergency Medical Evacuation of \$25,000.	Up to the Maximum policy limit per Period of Coverage; Maximum Lifetime Limit for Emergency Medical Evacuation of \$25,000.	Up to the Maximum policy limit per Period of Coverage Maximum Lifetime Limit for Emergency Medical Evacuation of \$25,000.	Up to the Maximum policy limit per Period of Coverage; Maximum Lifetime Limit for Emergency Medical Evacuation of \$25,000.	Up to the Maximum policy limit per Period of Coverage Upon attaining age 70 benefits will be reduced to a maximum of \$25,000. Maximum Lifetime Limit for Emergency Medical Evacuation of \$25,000.
Pre-certification	50% reduction of Eligible Medical Expenses if Pre-certification provisions are not met	50% reduction of Eligible Medical Expenses if Pre-certification provisions are not met	50% reduction of Eligible Medical Expenses if Pre-certification provisions are not met	50% reduction of Eligible Medical Expenses if Pre-certification provisions are not met	50% reduction of Eligible Medical Expenses if Pre-certification provisions are not met
Travel Assistance by GBG Assist	Included	Included	Included	Included	Included
* these benefits are not subject to teh deductible					



GENERAL TERMS OF COVERAGE

1. This policy is compliant with European Schengen and visa requirements for most countries. Entry requirements change frequently, please check with your respective country of destination about visa and entry requirements. GBG and/or its subsidiaries and business partners are not responsible for compliance with these regulations.
2. Trip Maximum Issuance: Maximum duration not to exceed 364 days and may not be combined with any other policy to exceed this limit.
3. Contiguous policy, extensions and refund of days:
 - a. This policy has a one-time renewable feature that must be completed PRIOR to expiry of the existing policy.
 - b. Policy renewal and extension may be for any period not exceeding one additional period of 364 days.
 - c. The purchase of any policy in conjunction with the expiry of another policy is void unless it is subject to the one-time renewal. Any further policy issuance is subject to underwriting and must be approved by GBG.
4. Maximum Age: Coverage ceases on the Insured Person's 90th birthday.
5. All claims must be submitted within 90 days from date of incident or they will be denied. Circumstances may exist in which this is not always possible. Any submissions after 90 days will be considered based on those circumstances.
6. All claims arising under this insurance shall be governed by the Laws of the Bailiwick of Guernsey, Channel Islands, whose courts alone shall have jurisdiction in any dispute arising hereunder.
7. If the Insured Person or any person acting on his/her behalf shall make any claim or statement knowing the same to be false or fraudulent in regards to amount or otherwise, then this Insurance shall become void and all claims hereunder shall be forfeited without refund of premium.
8. The Insurer may at their own expense take proceedings in the name of the Insured Person to recover compensation or secure an indemnity from any third party in respect of any loss, damage or expense covered by this Insurance and any amount so recovered or secured shall belong to the Insurer.
9. The Insured Person must exercise reasonable care to prevent accident, Injury, loss or damage and at all times act as if uninsured.
10. Client must notify the Plan Administrator within 30 days of a change of address or domicile.
11. This policy does not cover any type of sports Injury or Sickness.
12. The Company maintains its right to investigate to verify that the eligibility requirements have been met. If and whenever the Company discovers that the eligibility requirements have not been met, its only obligation is refund of premium. Greencard Holders are not eligible for this coverage.
13. The Insured must arrive in the USA before traveling to other countries.
14. Coverage in countries outside the USA and your Home Country is available for up to 180 days during your Policy Period.



REFUND PROCEDURE AND POLICY CANCELLATION

Cancellation and refund will only be considered if written request is received by Us prior to the Effective Date of Coverage as listed on the certificate. If written request is received after the Effective Date of coverage, the following conditions apply if the Insured Person wishes to cancel the insurance and a written partial refund request has been made: (a) If any claims have been filed with the Company, the Premium is fully earned and is non-refundable. (b) If no claims have been filed with the Company, then a cancellation fee of US \$ 25 will be charged and only full month premiums will be considered as refundable; and (c) If after a refund is made, if it is determined that a claim was presented to the company on an Insured Person's behalf, the Insured Person will be fully responsible for that claim in its entirety.

POLICY TERMS & CONDITIONS

Hospital Benefits

Inpatient Hospital Benefits – As specified in the Schedule of Benefits

Inpatient means a person was admitted to an approved Hospital or other health care facility for a medically necessary overnight stay. Hospitalization services include, but are not limited to, semi-private room and board (as listed in the Schedule of Benefits and as designated by your plan selection), general nursing care and the following additional facilities;: services and supplies as Medically Necessary and approved and covered by the Policy, meals and special diets (only for the patient), use of operating room and related facilities, use of intensive care and related services to include x-ray, laboratory and other diagnostic tests, drugs, medications, biological anesthesia and oxygen services, radiation therapy, inhalation therapy, chemotherapy and administration of blood products. All inpatient ancillary benefits are paid in accordance with the current Schedule of Benefits.

Inpatient Services

Benefits are provided per the Schedule of Benefits for medically necessary inpatient Hospital care.

Accommodations

Coverage is provided for room and board, special diets and general nursing care. All charges in excess of the allowable semiprivate rate are the responsibility of the Insured.

Intensive Care Units

Benefits will be provided based on the Allowable Charge for medically necessary Intensive Care services.

Inpatient Ancillary Hospital Services - If medically necessary for the Diagnosis and treatment of the Sickness or Injury for which an Insured Person is hospitalized, the following services are also covered:

Use of operation room and recovery room;

All medicines listed in the U.S. Pharmacopoeia or National Formulary;

Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services

Surgical dressings;

Laboratory testing;

Durable medical equipment;

Diagnostic X-ray examinations;

Radiation therapy rendered by a radiologist for proven malignancy or neoplastic diseases;

Respiratory therapy rendered by a Physician or registered respiratory therapist;

Chemotherapy rendered by a Physician or Nurse under the direction of a Physician;

Physical and Occupational therapy (if covered) must be rendered by a Physician or registered physical or occupational therapist and relate specifically to the physician's written treatment plan. Therapy must: Produce significant improvement in the Insured's condition in a reasonable and predictable period of time, and Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist, or Be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered.

All Inpatient Ancillary benefits are paid in accordance with the current Schedule of Benefits.

Hospital Outpatient Benefit – See Hospital Benefits



Outpatient Hospital Benefits – As specified in the schedule of benefits Outpatient means a person is admitted to an approved hospital or other healthcare facility for treatment that does not require an overnight stay. This policy provides the same level of benefits whether you are an INPATIENT or OUTPATIENT. However, as an outpatient there is no coverage for hospital stay or board.

Other Treatment and Services:

Emergency Ground Ambulance Services

Benefits are provided for medically necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care and are payable in accordance with the Schedule of Benefits;

Initial Orthopedic Prosthesis/brace

Prosthesis and corrective devices such as Durable Medical Equipment which are medically required as an integral part of treatment prescribed by a physician; Prosthesis/ Durable Medical Equipment does not include: motor driven wheelchairs or bed; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies; exercise cycles, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment, and similar items;

Chemotherapy and/or radiation therapy – covered under Inpatient Ancillary Hospital Services

Emergency Dental Benefit - Emergency dental treatment and restoration of sound natural teeth; required as a result of an Accident; Benefit limited to \$600; Routine dental treatment not covered.

Mental Health Benefits - Inpatient/Outpatient Services Benefits are provided for psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric Diagnosis and are payable as follows and in accordance with the current Schedule of Benefits.

Outpatient Mental Health - As set forth in the Schedule of Benefits

Benefits are for both inpatient mental health treatment in Hospital, or approved facility and for outpatient mental health treatment and will be applied toward the Policy Year per person Maximum. A Physician or a licensed clinical psychologist must provide all mental health care services. Services of a clinical psychologist must be rendered in the provider's office or in the outpatient department of a Hospital. Services Include treatment for Bulimia; Anorexia; Non-medical causes of insomnia; All Outpatient & Inpatient rehabilitation treatment programs must be Pre-authorized.

The following services are excluded: Aptitude testing, educational testing and services; Services for conditions not determined by Insurer as to be emotional or personality Sicknesses; Psychiatric services extending beyond the period necessary for evaluation and Diagnosis of mental deficiency or retardation; Services for mental disorders or Sickness which are not amenable to favorable modification; Bereavement; Family counseling of any kind; Marriage counseling of any kind.

Sudden and Acute Onset of a Pre-existing Condition(s) Up to the Maximum policy limit per Period of Coverage with age limit of having attained the age of 70. Upon attaining age 70 benefits will be reduced to a maximum of \$10,000 per Period of Coverage: Maximum Lifetime Limit for Emergency Medical Evacuation is \$25,000. Any repeat/reoccurrence within the same Period of Coverage is no longer to be considered Sudden and Acute and will not be eligible for additional coverage.

Outpatient Physical Therapy - See the Schedule of Benefits

Emergency Medical Evacuation

The plan covers the cost of emergency evacuation – when deemed necessary and pre-approved by GBG Assist – to a suitable location to render immediate and appropriate care. GBG Assist will determine the destination country of the evacuation, and the country may or may not be the home country of origin. If the Insured does not obtain pre-approval from GBG Assist, GBG reserves the right to deny coverage or assess a 20% co-payment for the associated costs. Limit of \$25,000 for Medical Evacuation due to Acute Onset of a Pre-existing Condition. Repatriation for Medical Treatment: GBG reserves the right to review any case in which the Insured Person is medically stable and upon advice of GBG Assist medical doctors can be evacuated at GBG's discretion to the home country of residence.

Repatriation of Mortal Remains

We will pay 100% up to the amount listed in the Schedule of Benefits for preparation and return of your body to your Home Country if you die due to a Covered Injury or Sickness. Covered Expenses include: Expenses for embalming or cremation; The least costly coffin or receptacle adequate for transporting the remains; Transporting the remains by the most direct and least costly conveyance and route possible and Pre-approved by GBG Assist. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences.

Natural Disasters, Political Evacuation and Repatriation



Provides a benefit for evacuation during a period of civil unrest, insurrection or natural disasters that could not have been foreseen prior to departure from home country of origin. Coverage is NOT valid in any country that was on verge, already in or under duress for a period of 60 days prior to departure from point of origin or country of residence. The coverage amount is in the Schedule of Benefits.

Return of Minor Children

If traveling alone and with a child under the age of 18 and the Insured Person falls ill and is hospitalized due to a covered Sickness resulting in a minor child being left unattended, then the plan will pay for one-way transportation via economy commercial common carrier to their Home Country. It also includes the cost of an escort should that be deemed required for the safety and wellbeing of the minor.

Continuation of Treatment Period

If a covered Injury or Illness requires continuing Treatment after the expiration of the Period of Coverage, an Insured Person may receive continuing Treatment for the covered Injury or Illness for up to 6 months per Injury or Illness, subject to the following: if the Period of Coverage expires while the Insured Person is outside the Home Country, a covered Injury or Illness incurred while outside and prior to returning to the Home Country, and that covered Injury or Illness requires continuing Treatment, the Company will review and determine the date of initial Treatment for the covered Injury or Illness, and if such date is prior to the expiration of the Period of Coverage, Eligible Medical Expenses for the covered Injury or Illness will continue to be reimbursed until there has been at least the minimum number of days of continuous Treatment for the covered Injury or Illness, subject to the limits set forth in the Schedule of Benefits/Limits, and all other Terms of the insurance plan. In order to be eligible for coverage under the Continuation of Treatment Period provision, the Insured Person must be covered by an insurance policy, benefit plan, or Other Coverage for expenses or charges incurred by the Insured Person, and the Other Coverage remains in effect during the duration of coverage with the Company.

Return to Home Coverage: You may return to your home country of residence for up to 30, 60 or 90 days - Based on Plan Purchase during the Policy Period. The benefits available are those as outlined in the Schedule of Benefits and may ONLY be utilized after initially leaving the home country of residence and then returning for an incidental trip. The benefits are subject to any policy limitations and all of the exclusions. Home Country will be the one declared in writing at the time of application. NOT AVAILABLE on the DIAMOND plans.

Common Carrier AD&D Principal Sum: Accidental Death and Dismemberment will apply to covered Accidents incurred by the Insured Person while traveling/riding as a passenger in or on any public land, water or air conveyance (regularly scheduled and licensed) for transportation of passengers for hire. Losses must occur within one year (365 days) from the date of Accident.

Loss of Life	100%
Loss of Speech and Loss of Hearing	100%
Loss of Speech and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100%
Loss of Hearing and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100%
Loss of Hands (Both), Loss of Feet (Both), Loss of Sight or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of Hand, Loss of Foot or Loss of Sight of One Eye (any one of each)	50%
Uniplegia	25%
Loss of Thumb and Index Finger of the same hand	25%

Felonious Assault

We will pay the Benefit Amount for Felonious Assault shown in the Schedule of Benefits, if Accidental Bodily Injury resulting from Felonious Assault causes a Primary Insured Person to suffer Covered Loss. The Benefit Amount for Felonious Assault is payable in addition to any other applicable Benefit Amounts under this policy. Any assault by a family member is not covered under this benefit.



DEFINITIONS

Please note, certain words used in this document have specific meanings.

“Acute Onset of a Pre-Existing Condition” means a sudden and unexpected outbreak or recurrence of a Pre-existing Condition which occurs 1) spontaneously and without advance warning either in the form of Physician recommendations or symptoms, is of short duration, is rapidly progressive, and requires urgent and immediate medical care; 2) is a minimum of 48 hours after the Effective Date of the policy; and 3) prior to the age shown in the Schedule of Benefits/Limits with treatment being obtained within 24 hours of the sudden and unexpected outbreak or recurrence.

“Covered Expenses” means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by the Policy. Coverage under the Policy must remain continuously in force from the date of the Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

“Deductible” means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Insured Person on a per incidence basis. The deductible must be met, by the Insured Person before Medical Expense Benefits can be paid or reimbursed. The deductible is applied to the first eligible claim processed.

“Home Country” means a country from which the Insured Person holds a passport. If the Insured Person holds passports from more than one country, his or her Home Country will be that country which the Insured Person has declared to Us in writing as his or her Home Country.

“Policy Period” means the dates as shown on your certificate for which premium has been paid.

“Medical Emergency” means a condition caused by an Injury or Sickness that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

“Pre-Existing Condition” means Any Injury, Illness, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment that, with reasonable medical certainty, existed at the time of Application or at any time during the two (2) years prior to the Effective Date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, Treated, or disclosed to the Company prior to the Effective Date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom. A Pre-existing Condition which is a chronic or congenital condition or that gradually becomes worse over time and/or known, scheduled, required, or expected medical care, drugs or Treatments existing or necessary prior to the Effective Date are not considered to be an Acute Onset.

“Pre-certification; Pre-certify” means a general determination of Medical Necessity only, made by the Company in reliance and based upon the completeness and accuracy of the information provided by the Insured Person and/or the Insured Person's healthcare or medical service providers, guardians, Relatives and/or proxies at the time thereof. Pre-certification is not an assurance, authorization, pre-authorization or verification of coverage, a verification of benefits, or a guarantee of payment.

“Usual and Customary Charge” means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

“We”, “Insurer”, “Our”, “Us” means GBG Insurance Limited and or its affiliated insurers.

GENERAL EXCLUSIONS - APPLIES TO ALL SECTIONS OF COVERAGE

Unless specified in the Schedule of Benefits, in any written endorsement, or agreed by the Company in writing, no claim can be made for compensation or payment for damage or expenses caused by or as a result of the following:

1. Pre-Existing Conditions as defined.
2. Costs related to medical examination, treatment and surgical intervention which are not administered in a licensed healthcare institution.
3. Costs related to medical examination where no Sickness has been diagnosed or Accident has been ascertained; for non-specified pain; or preventative or routine exams.
4. Any visit to a medical provider that does not result in a covered Diagnosis code after medical review or testing.
5. Any treatment by a family member/family associate or any type of direct relationship.
6. In respect of accidental damage to Natural Teeth, no benefit is payable for Injury caused by eating or drinking (even if it contains a foreign body), normal wear and tear, tooth brushing or any other oral hygiene procedure or any means other than extra-oral impact, any form of restorative or remedial work, the use of precious metals, orthodontic treatment of any kind or dental treatment performed in a hospital unless dental surgery is the only treatment available.
7. Suicide or attempted suicide, intentional self-injury, the effect of intoxicating liquors or drugs.
8. Treatment of hernia, Osgood-Schlatter's Disease, osteochondritis, osteomyelitis, cardiac disease or conditions (including lipedema – high cholesterol), pathological fractures, congenital weakness whether or not caused by a Covered Accident.
9. Evacuation costs where the Insured Person is not being admitted to a Hospital for Treatment or where costs have not been approved by



- Company prior to travel commencing.
10. Any costs arising after expiry of the current Policy Period unless this plan has been renewed for a subsequent 12 months or the Insured Person was being treated during the Policy Period as a result of an accident.
 11. Any form of treatment or surgery which in the opinion of the Doctors(s) in attendance and GBG Assist that can be delayed until your return to your home country.
 12. Medical Expenses incurred after you have returned to your home country which exceed the number of days or in excess of a limit stated in the Schedule of Benefits.
 13. Medical Expenses in excess of a limit stated in the Schedule of Benefits.
 14. The amount of the Policy Excess, Deductible or Co-Payment, as stated in the Schedule of Benefits.
 15. Any cost resulting in a Sickness, Injury or death from the misuse of drugs or being under the influence or effect of alcohol (other than a legally prescribed medication by a licensed medical professional).
 16. Needless self-exposure to peril except in an attempt to save human life.
 17. Intentional or fraudulent acts on the Insured Person's part or their consequences.
 18. Trips specifically made for the purpose of obtaining medical treatment.
 19. Cosmetic surgery or remedial surgery, removal of fat or other surplus body tissue and any consequences of such treatment, weight loss or weight problems/eating disorders, whether or not for psychological purposes, unless required as a direct result of an Accident which occurs during the Policy Period.
 20. Treatment for alcoholism, narcotics, drug and substance abuse/dependency or any addictive condition of any kind and any Injury or Sickness arising from the Insured Person being under the influence of alcohol, drugs or any other intoxicating substance.
 21. Pregnancy, childbirth whether normal or complicated, including the transfer of a pregnant woman to hospital to give routine childbirth or air travel when the Insured Person is more than 20 weeks pregnant and was NOT a result of an accident or onset of complications relating from an accident.
 22. Any sexually transmitted or venereal disease; and/or any testing for the following: HIV, Vaccine induced seropositivity to the AIDS virus, AIDS related illnesses, ARC Syndrome, AIDS.
 23. Treatment for transitional life Events, homesickness, fatigue, jet-lag or work related stress.
 24. Any loss as the result of the use of any type of firearm(s) (Defined as any device that discharges a projectile of any type).
 25. Any expenses relating to search and rescue operations to find an Insured Person in mountains, at sea, in the desert, in the jungle and similar remote locations, including air/sea rescue charges for evacuation to shore from a vessel or from the sea.
 26. Charges or fees incurred for the completion of Medical Claim Forms.
 27. Any expenses as the result of or related to participating in any sports or sport related activity. Inclusive of conditions that arise out of sport activity including but not limited to Cardiac, Respiratory, Orthopedic conditions etc.
 28. Any loss as the result of the use of a Motorcycle or two or three wheeled device of any kind.
 29. The radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component thereof.
 30. War Insurrection and Terrorism related to the following: Nuclear, and Weapons of mass destruction: means the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people or animals. Chemical Weapons: mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals. Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing incapacitating disablement or death amongst people or animals. Terrorism: Terrorist activity means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization(s) or governments(s).
 31. Any infection of the urinary tract (including, without limitation, infection of the kidney, ureter, bladder, prostate or urethra) and any complication, medical condition or other illness directly or indirectly arising therefrom, that occurs within ninety (90) days of the Effective Date of this Insurance and that requires Treatment of the Insured Person in a Hospital as an inpatient.
 32. Any loss that is occurred in a country, other than the USA, where the stay exceeds 180 days.



CLAIM PROCEDURES

Claims Submission:

- All claims must be submitted to GBG within 90 days of the date of service.
- All claims MUST BE ON A FULLY COMPLETED claim form including medical history sections. A claim form must be completed and provided for each medical condition.
- Download a claim form: <http://www.trawickinternational.com/Claims> or call 888-301-9289 and one will be sent to you.
- Claims may be mailed, faxed, or scanned and emailed. Contact details provided below.
- A copy of your passport with entry/exit/visa stamps is required.
- Detailed bills for services received and detailed receipts for payments made.
- A signed authorization from the Insured is necessary to reimburse any person other than the Insured.
- GBG will contact you via email if they need anything.

Notice of Claim: This notice should identify the Covered Person and the Policy Number. All claims must be submitted within 90 days from date of incident or they will be denied. Circumstances may exist in which this is not always possible. Any submissions after 90 days will be considered based on those circumstances.

Proof of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. The proof must describe the occurrence, extent and nature of the loss and give authorization to release medical records.

Claimant Cooperation Provision: Failure of a claimant to cooperate with Us in the administration of a claim may result in the delay or termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Time Payment of Claims: Benefits for loss covered by the Policy, other than benefits that require periodic payment, will be paid not more than 60 days after We receive proper written proof of such loss.

Payment of Claims: If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Covered Person(s): 1. spouse; 2. children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian); 3. mother or father; 4. estate. All other benefits due and not assigned will be paid to the Covered Person, if living. Otherwise, the benefits may, at our option, be paid: 1. according to the beneficiary designation; or 2. to the Covered Person's estate. If a benefit due is payable to: 1. the Covered Person's estate; or 2. the Covered Person or a beneficiary who is either a minor or is not competent to give a valid release for the payment, We may pay any amount due to some other person. The other person will be one who we believe is entitled to the payment and who is related to the Covered Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith. We may pay benefits directly to any Hospital or person rendering covered services, unless the Covered Person requests otherwise in writing. The Covered Person must make the request no later than the time he or she files a written proof of loss.

Beneficiary: The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change. The Insured is the beneficiary for any covered Dependent.

Assignment: At the request of the Covered Person or his or her parent or guardian, if the Covered Person is a minor, medical benefits may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.

Physical Examinations and Autopsy: We have the right to have a Doctor of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy: 1. before 60 days following the date proof of loss was given to Us; or 2. after 3 years following the date proof of loss is required. **Not in Lieu of Workers' Compensation:** The Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

Fraud Warning: If the Insured Person or any person acting on his/her behalf shall make any claim or statement knowing the same to be false or fraudulent as regards to an amount or otherwise, then this Insurance shall become void and all claims here under shall be forfeited without refund of premium.

Payment of loss under this policy shall only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").



ACCESSING YOUR BENEFITS VIA NETWORK PROVIDERS AND PRE CERTIFICATION

Emergency Care: In an EMERGENCY SITUATION, call for emergency assistance (911 in the United States) and go to the closest emergency facility. If you are not sure where to go you may contact GBG Assist at the number on your ID card and they may be able to direct you to the closest network facility. Remember, it is your health so you must act prudently in an emergency and seek the care you need.

Non-Emergency Care: When a non-emergency situation arises in which you need to visit a medical professional please utilize a local doctor, walk-in clinic or urgent care facility. You can locate one by using the web address on the back of your ID card. Going to a hospital emergency room for NON-Emergency care will result in additional expenses and out of pocket cost as specified in your Schedule of Benefits.

Examples of Non-Emergency care include: sore throat, common cold, minor Injuries and Sicknesses that are not life threatening. NOTE: This policy excludes Injury or Sickness related to sports activity. Please see exclusion section.

Preferred Provider Network

The Company maintains a Preferred Provider Network both within and outside the United States. Within the United States, the Company recommends the use of the Preferred Provider Network for maximum benefit payment. Outside the U.S., the Company retains the right to require the use of a Network Provider, where available. Utilizing these providers may result in payments directly to the provider as well as referrals to licensed medical providers you can trust. You can find the link to the provider directory on the back of your ID card or at <https://www.trawickinternational.com/resources/find-a-healthcare-provider> Or be subject to a 20% copayment on all claims.

In the United States, provider choices and reimbursement assessment will be based as follows:

In-Network Preferred Provider: This tier consists of all In-Network Providers as well as other preferred providers designated by the Company [and listed on the website]. In-Network Providers have agreed to accept a negotiated discount for services. This results in lower out-of-pocket costs to the Insured.

Out-of-Network Provider: Utilizing providers that are Out-of-Network is a more costly financial option for the Insured. The Company reimburses such providers up to a Reasonable and Customary amount as determined by the Company. The provider may bill the Insured the difference between the amounts reimbursed by the Company and the Provider's billed charge. Additionally, the Insured will pay a Coinsurance amount that is higher than if an In-Network Provider were used. Amounts in excess of the Reasonable and Customary charges will not count toward the Out-of-Pocket Maximum, Deductibles or Plan Co-payments.

Pre Certification/Notification: Pre-certification and notification to GBG Assist is mandatory. Failure to do so will result in a 50% reduction of the eligible claims Medical Expenses. For pre-Certification please contact: GBG Assist Toll Free USA and Canada 877-916-7920 Worldwide Collect 949-916-7941

Provisions/Requirements

Pre-certification is a general determination of Medical Necessity, only, and all such determinations are made by the Company (acting through its authorized agents and representatives) in reliance and based upon the completeness and accuracy of the information provided by the Insured Person and/or his/her relatives, guardians and/or healthcare providers at the time of Pre-certification. The Company reserves the right to challenge, dispute and/or revoke a prior determination of Medical Necessity based upon subsequent information obtained. Precertification is not an assurance, authorization, preauthorization, or verification of Treatment or coverage, a verification of benefits, or a guarantee of payment. The fact that Treatment or supplies are Pre-certified by the Company does not guarantee the payment of benefits, the availability of coverage, or the amount of or eligibility for benefits. The Company's consideration and determination of a Pre-certification request, as well as any subsequent review or adjudication of all medical claims submitted in connection therewith, shall remain subject to all of the Terms of the Master Policy and this Certificate, including exclusions for Pre-existing Conditions and other designated exclusions, benefit limitations and sub-limitations, and the requirement that claims be Usual, Reasonable and Customary. Also, any consideration or determination of a Pre-certification request shall not be deemed or considered as the Company's approval, authorization or ratification of, recommendation for, or consent to any diagnosis or proposed course of Treatment. Neither the Company nor the Plan Administrator (nor anyone acting on their respective behalves) has any authority or obligation to select Physicians, Hospitals, or other healthcare providers for the Insured Person, or to make any diagnosis or medical Treatment decisions on behalf of the Insured Person, and all such decisions must be made solely and exclusively by the Insured Person and/or his/her family members or guardians, treating Physicians and other healthcare providers. If the Insured Person and his/her healthcare providers comply with the Pre-certification requirements of the Master Policy and this Certificate, and the Treatment or supplies are Pre-certified as Medically Necessary, the Company will reimburse the Insured Person for Eligible Medical Expenses up to the amount shown in the Schedule of Benefits/Limits incurred in relation thereto, subject to all Terms of this insurance. Eligibility for and payment of benefits are subject to all of the Terms of this insurance.



Specific Requirements

The following must always be Pre-certified for Medical Necessity by the Company through the Plan Administrator before admission or receiving the Treatments and/or supplies:

Emergency Pre-certification - In the event of an Emergency Hospital admission, Pre-certification must be completed within forty-eight (48) hours after the admission, or as soon as is reasonably possible.

- a) Inpatient status.
- b) any Surgery or Surgical procedure.
- c) any Treatment in an Extended Care Facility.
- d) Durable Medical Equipment.
- e) artificial limbs.
- f) Computerized Axial Tomography (CAT Scan).
- g) Magnetic Resonance Imaging (MRI).

General Requirements

To comply with the Pre-certification requirements of this insurance for the Treatments and/or supplies or services listed in the section above, the Insured Person or his/her Physician or healthcare provider must:

- a) contact the Company through the Plan Administrator at the telephone numbers printed on the Insured Person's ID card, as soon as possible and before the Treatment or supply is to be obtained; and
- b) comply with the instructions of the Company and submit any information or documents required by the Company; and
- c) notify all Physicians, Hospitals and other healthcare providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.

Loss of Coverage/Benefits for Non-Compliance with Pre-Certification Requirements

If the Insured Person or his/her healthcare providers do not comply with the foregoing Pre-certification requirements, all Eligible Medical Expenses incurred with respect to said Treatments and/or supplies will first be reduced by fifty percent (50%), the applicable Deductible will be subtracted from the reduced amount, the Coinsurance will then be applied to the remainder of the reduced amount as applicable, and further benefits, if any under the insurance plan shown in the Declaration, will be available only for the remaining balance of the reduced amount thereafter.

Emergency Pre-certification - In the event of an Emergency Hospital admission, Pre-certification must be completed within forty-eight (48) hours after the admission, or as soon as is reasonably possible.



RATES - BASIC PLAN

Rates are based on Age and Plan/Deductible chosen. Plan is available from ages 14 days up to age 69.

BASIC - \$0 DEDUCTIBLE \$50,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$0 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$37.50	\$1.30
19-29	\$32.00	\$1.10
30-39	\$35.00	\$1.20
40-49	\$38.00	\$1.30
50-59	\$52.00	\$1.75
60-69	\$57.50	\$1.90

BASIC - \$50 DEDUCTIBLE \$50,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$50 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$31.50	\$1.05
19-29	\$26.00	\$0.85
30-39	\$29.50	\$1.00
40-49	\$31.50	\$1.05
50-59	\$43.50	\$1.45
60-69	\$47.50	\$1.60

BASIC - \$100 DEDUCTIBLE \$50,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$100 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$29.50	\$1.00
19-29	\$24.00	\$0.80
30-39	\$27.00	\$0.90
40-49	\$29.50	\$1.00
50-59	\$40.00	\$1.30
60-69	\$44.00	\$1.50



RATES - SILVER PLAN

Rates are based on Age and Plan/Deductible chosen. Plan is available from age 14 days up to age 69

SILVER - \$0 DEDUCTIBLE \$75,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$0 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$44.00	\$1.50
19-29	\$36.50	\$1.25
30-39	\$41.50	\$1.40
40-49	\$44.00	\$1.50
50-59	\$60.50	\$2.00
60-69	\$67.00	\$2.20

SILVER - \$50 DEDUCTIBLE \$75,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$50 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$36.50	\$1.25
19-29	\$30.50	\$1.00
30-39	\$34.00	\$1.15
40-49	\$36.50	\$1.25
50-59	\$50.00	\$1.65
60-69	\$56.00	\$1.85

SILVER - \$100 DEDUCTIBLE \$75,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$100 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$34.00	\$1.15
19-29	\$28.50	\$0.95
30-39	\$31.50	\$1.05
40-49	\$34.00	\$1.15
50-59	\$47.50	\$1.55
60-69	\$53.50	\$1.80



RATES - GOLD PLAN

Rates are based on Age and Plan/Deductible chosen. Plan is available from age 14 days up to age 69.

GOLD - \$0 DEDUCTIBLE \$100,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$0 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$51.00	\$1.70
19-29	\$42.50	\$1.40
30-39	\$47.50	\$1.55
40-49	\$51.00	\$1.70
50-59	\$69.00	\$2.30

GOLD - \$50 DEDUCTIBLE \$100,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$50 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$42.50	\$1.40
19-29	\$35.00	\$1.15
30-39	\$39.00	\$1.30
40-49	\$42.50	\$1.40
50-59	\$56.50	\$1.90
60-69	\$63.50	\$2.15

GOLD - \$100 DEDUCTIBLE \$100,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$100 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$39.00	\$1.30
19-29	\$32.50	\$1.05
30-39	\$36.50	\$1.20
40-49	\$39.00	\$1.30
50-59	\$56.00	\$1.85
60-69	\$61.50	\$2.05



RATES - PLATINUM PLAN

Rates are based on Age and Plan/Deductible chosen. Plan is available from age 14 days up to age 69.

PLATINUM- \$0 DEDUCTIBLE \$175,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$0 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$67.00	\$2.20
19-29	\$55.50	\$1.85
30-39	\$62.00	\$2.05
40-49	\$67.00	\$2.20
50-59	\$88.50	\$3.00
60-69	\$98.50	\$3.30

PLATINUM- \$50 DEDUCTIBLE \$175,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$50 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$55.50	\$1.85
19-29	\$45.00	\$1.55
30-39	\$51.00	\$1.70
40-49	\$55.50	\$1.85
50-59	\$74.50	\$2.45
60-69	\$83.00	\$2.75

PLATINUM- \$100 DEDUCTIBLE \$175,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM

\$100 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
14 Days -18 Years	\$52.00	\$1.70
19-29	\$42.50	\$1.40
30-39	\$47.50	\$1.55
40-49	\$52.00	\$1.70
50-59	\$72.00	\$2.40
60-69	\$80.50	\$2.70



DIAMOND PLAN RATES

Rates are based on Age and Plan/Deductible chosen. Coverage is available from ages 50 up to age 89, however all coverage ends upon reaching age 90.

MONTHLY/DAILY PREMIUMS FOR AGES 50 TO 89

DIAMOND- \$100 DEDUCTIBLE \$50,000 PER INJURY OR SICKNESS MEDICAL MAXIMUM \$100 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
50-59	\$40.00	\$1.30
60-69	\$44.00	\$1.50
70-74	\$74.50	\$2.50
75-79	\$82.00	\$2.75
80-84	\$166.00	\$5.55
85-89	\$239.50	\$8.00

DIAMOND \$200 DEDUCTIBLE \$100 Per Injury / Sickness Deductible Per Person

Ages	Monthly	Daily
50-59	\$33.00	\$1.10
60-69	\$36.50	\$1.25
70-74	\$61.50	\$2.10
75-79	\$68.50	\$2.30
80-84	\$139.00	\$4.60
85-89	\$204.00	\$6.80



INSURED INFORMATION - When there are two or more people on the same application they must choose the same plan.

Insured # 1 Last Name: _____

Insured # First Name and MI: _____

Passport Number/Issuing Country: _____ Gender _____

Insured #2 Last Name: _____

Insured #2 First Name and MI: _____

Passport Number/Issuing Country: _____ Gender _____

Insured #3 Last Name: _____

Insured #3 First Name and MI: _____

Passport Number/Issuing Country: _____ Gender _____

Insured #4 Last Name: _____

Insured #4 First Name and MI: _____

Passport Number/Issuing Country: _____ Gender _____

HomeCountryAddress: _____

Destination: _____

AD&D Beneficiary: _____ Relationship: _____

Phone: (____) _____ Email Address: _____

When did or will you arrive in the United States: ____/____/____ (MM/DD/YY)

Date to begin coverage: ____/____/____ (MM/DD/YY) Date to end coverage: ____/____/____ (MM/DD/YY)

Note: This program is not available to United States citizens. Your coverage must begin within 12 months of your arrival in the United States. The minimum period of coverage is 5 days, maximum is 364 days. Total program length available is 364 days. Coverage cannot begin until you depart from your home Country and Trawick International both receives and accepts your application and correct premium.

PLAN CHOICES (CIRCLE ONE)

Plans ages 14 days to 69 years:

Basic \$0 Deductible	Silver \$0 Deductible	Gold \$0 Deductible	Platinum \$0 Deductible
Basic \$50 Deductible	Silver \$50 Deductible	Gold \$50 Deductible	Platinum \$50 Deductible
Basic \$100 Deductible	Silver \$100 Deductible	Gold \$100 Deductible	Platinum \$100 Deductible

Plans ages 50 to *89 years: (*age 89 can be enrolled, however, coverage can only be purchased up to the date of someone's 90th birthday)

Diamond \$100 Deductible Diamond \$200 Deductible



RATE CALCULATOR

Personal Information	DailyRate (from chart above)	Monthly Rate (from chart above)
Insured #1		
Insured #2		
Insured #3		
Insured #4		
Number of days or months	x	x
	\$	\$
TOTAL PREMIUM - DAILY RATE PLUS MONTHLY RATE		\$

Method of Payment

Make Check or Money Order payable to "Icon Services Inc." and must be in U.S. dollars and from a US bank.

Check
 Money Order
 MasterCard
 Visa
 Discover
 American Express

Card Number: _____ Expiration Date: (MM/YY) _____ / _____ CVV: _____

Name on Card: _____ Daytime Phone: (_____) _____

Address: _____

City: _____ State: _____ Postal Code: _____ Country: _____

If paying by credit card, I authorize Icon Services Inc. to debit my Discover, VISA, MasterCard or American Express account for the amount specified above. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. Total payment for the initial term of coverage requested must be entirely paid in U.S. dollars at time of Application or prior to the Effective Date of Coverage.

I understand this insurance contains a Pre-existing Condition exclusion, and other restrictions and exclusions. I understand that if I am eligible for renewal of this insurance that it may be transacted on line and only before my current coverage expiration date. I understand that the information contained herein is a summary of the certificate and that I will receive my certificate upon acceptance by Trawick. I understand that GBG Insurance Limited, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. Claims under this insurance may not be made against any state guaranty fund. I understand and agree that the agent/broker/representative, if any, assisting with this Application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant. I hereby apply for membership in the EGlobal Tourist Trust, Hamilton, Bermuda and for the insurance provided to me by GBG Insurance Limited I understand that the insurance applied for is not a general health insurance policy, but is intended for use in the event of a sudden or unexpected event while traveling outside my Home Country as declared on my application.

_____/_____/_____
 Signature of Insured or Proxy (Required) Date
 (Proxy is someone acting on behalf of Insured)

Agent Name/Writing Number _____ - _____



Agent Information



Plan Administrator
Trawick International Inc.
1956-J University Blvd. S. #264
Mobile, Alabama 36609

Toll Free: 888-301-9289 Direct: 251-661-0924
Email: Info@trawickinternational.com

Insurance Company:
GBG Insurance Limited

