



Policyholder: \_\_\_\_\_ Tel: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_ Email: \_\_\_\_\_

 Country(ies) to be visited: \_\_\_\_\_ Country of Origin \_\_\_\_\_  
*(if different from home address)*
**Coverage Selected:** (please  appropriate box):  Plan A  Plan B  Plan C **Premium Type:**  Individual  Family

**Period of Insurance:** From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (MM/DD/YY) for \_\_\_\_\_ days

Name of Insured Person (Last Name / First Name)	Sex	Date of Birth (MM/DD/YY)	Passport No.	Optional Rental Car Protection Period of Insurance (MM/DD/YY)				Premium US\$
				From	/	/	for days	
				From	/	/	for days	
				From	/	/	for days	
				From	/	/	for days	
				From	/	/	for days	
				From	/	/	for days	
<b>Total premium of this policy:</b>								

I enclose my check for US\$ \_\_\_\_\_ payable to "Pacific Cross Insurance Company Limited".

 Please charge:  American Express  Visa  MasterCard Card No.: \_\_\_\_\_ Expiry Date (MM/YY) \_\_\_\_ / \_\_\_\_

Name of Cardholder: \_\_\_\_\_ Relationship to Policyholder: \_\_\_\_\_ Signature of Cardholder: \_\_\_\_\_

**Declaration:** I hereby apply for a Bon Voyage Travel Insurance Policy to be based on the above statements, and warrant that to the best of my knowledge and belief that no Insured Person is travelling contrary to the advice of a medical practitioner or for the purpose of obtaining medical treatment and that I understand treatment of any pre-existing, existing, recurring or congenital medical conditions is not insured. I further warrant that I am not aware of any condition, cause or circumstances that may necessitate the cancellation or curtailment of the journey as planned. I further authorize the Company to provide my personal data including but not limited to health and details of the claims incurred to reinsurance companies with whom the Company has or proposes to have dealings or to any agent, contractor or third party service provider who provides services to the Company in connection with the operation of its business.

Policyholder (if different from the Insured Person) \_\_\_\_\_ Date: \_\_\_\_\_ Broker: \_\_\_\_\_

