Please type or print in ink.

OFFICIAL USE ONLY -
Agent: 1265

LIAISON® STUDENT APPLICATION

PRIMARY APPLICANT INFORMATION

Last Name: _____

First Name: _____ M.I: _____

Residence Country: _____

TRIP INFORMATION

Destination Countries: _____

List all destinations for your trip. We cannot cover travel to Islamic Republic of Iran and Syrian Arab Republic.

Destination State if traveling to the U.S.: _____

Passport Country & Number: _____

Departure Date from your Residence Country? *(MM/DD/YY)*____/____/____

Coverage Start Date: *(MM/DD/YY)*____/____/____

Coverage End Date: *(MM/DD/YY)*____/____/____

The minimum coverage period is 5 days, the maximum is 364 days.

Important: *We cannot accept an address in these locations:*
States in the USA: Maryland , Washington, New York, South Dakota, Colorado. Canada, Australia, Switzerland, Islamic Republic of Iran, Syrian Arab Republic, U.S. Virgin Islands, Gambia, Ghana, Nigeria, and Sierra Leone.

Previously insured by Seven Corners? ❑ Yes ❑ No ID #: _____

MAILING ADDRESS:

Address: _____

City: _____ State: _____

Postal Code: _____ Country: _____

Work Phone: ( ) _____ Home Phone: ( ) _____

Email Address: _____

❑ I would not like to receive communications from Seven Corners and/or my agent about products in the future.

AD&D BENEFICIARY DETAILS

Beneficiary: _____

Relationship: _____

EDUCATIONAL INSTITUTION INFORMATION

Name of School or Educational Institution: _____

Select Visa ❑ J-1 ❑ H-3 ❑ F-1 ❑ M-1 ❑ Q-1
(Non-U.S. citizens only, not required for U.S. citizens)

Student ID Number (optional): _____

CHOOSING A PLAN

Please see page 5 for plan details and a list of daily rates.

U.S. CITIZENS, PLEASE CHOOSE A PLAN:
❑ Plan A ❑ Plan B ❑ Plan C ❑ Plan D ❑ Plan E ❑ Plan F

NON U.S. CITIZENS, PLEASE CHOOSE A PLAN:
❑ Plan G ❑ Plan H ❑ Plan I

Name of Persons to be Insured:	Date of Birth MM/DD/YY	Gender	Daily Rate (USD)
Primary: _____	___/___/___	❑M ❑F	_____
Spouse: _____	___/___/___	❑M ❑F	_____
Child: _____	___/___/___	❑M ❑F	_____
Child: _____	___/___/___	❑M ❑F	_____
Child: _____	___/___/___	❑M ❑F	_____

CALCULATING YOUR COST

1. Add the amounts in the Daily Rate column together. Enter the result on line 1. This your Daily Rate Total. 1._____
2. Enter your Total Number of Travel Days on line 2 (include all travel days, including the start and end dates for your trip). 2._____
3. Multiply line 1 by line 2. Enter the result on line 3. This is your Total Payment. 3._____

METHOD OF PAYMENT: ❑ Check ❑ Money Order ❑ MasterCard ❑ Visa ❑ Discover ❑ American Express

If paying by check or money order, make payable to World Commercial Trust and mail with your application to the address below. Checks must be issued from a US bank. If paying by credit card, you may mail or fax to us.
World Commercial Trust - P.O. Box: 56575, Station A - Toronto, ON M5W 4L1 Fax: 317-575-2659

Card Number: _____ Expiration Date: _____ Daytime Phone: ( ) _____

Name on Card: _____ Billing Address: _____

Signature *(Required)* _____ _____

I hereby subscribe to the World Commercial Trust and enroll in the group coverage for which I am eligible under the Master Policy issued by Certain Underwriters at Lloyd's, London. The premiums listed include a trust fee. Total payment for the full term of coverage requested must be paid in U.S. dollars at the time of application in order for coverage to be issued. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I understand that this coverage is not a general health insurance policy, but a limited benefit period, travel medical program intended for use while away from my Home Country. I understand that the information contained herein, in the program brochures and the Certificate of Insurance (Certificate) is a summary of the benefits to which I may be entitled under the Master Policy and if, there is any difference, the provisions of the Certificate shall prevail. I understand that I may obtain a copy of the Master Policy upon request to Seven Corners. I declare that I have read and understand the terms and conditions of this product. I understand that pre-existing conditions, as defined, are excluded, unless otherwise specifically noted as covered in the Certificate. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I understand that wherever coverage provided would be in violation of any law including U.S. or appropriate state law (including U.S. economic or trade sanctions), such coverage will be null and void. Seven Corners, Inc. and Certain Underwriters at Lloyd's are subject to sanctions, prohibitions or restrictions under UN resolutions or the trade or economic sanctions, laws or regulations of the European Union (EU), United Kingdom or the United States (including those administered by the Office of Foreign Assets Control (OFAC)). If your Home Country is subject to US, EU or UN sanctions or you are personally the subject of any sanctions or are a "Designated Person" for EU or OFAC purposes (or any similar regime in any other country), we cannot provide you coverage, and any Certificate sent to you will be null and void from its issuance. For the purposes of this program, "Home Country" is the country where you have your true, fixed and permanent residence. Notwithstanding the foregoing, for United States Citizens, the Home Country is always the United States.
I hereby certify that my Home Country is not currently subject to US, EU or UN sanctions and that I am not a Designated Person (or otherwise personally subject to any sanctions law).
THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH CARE COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWN AN ADDITIONAL PAYMENT WITH YOUR TAXES.
Residents of India who are seeking to procure this insurance online whilst in India are required to obtain permission from the Central Government and Reserve Bank of India prior to purchasing this insurance.

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