



OFFICIAL USE ONLY: Approved Eff. Date Source Code 1096

Primary Insured Information

Dr. Mr. Mrs. Ms.

Last Name

First Name

Home Country Address

Passport Country Passport # Visa Type

International Exchange Activity Information

Purpose of travel to the U.S. (select one):

- Academic/Educational Program J Visa Exchange Visitor Program Business Travel/Work Assignment Cultural Exchange Practical Training Spouse or Child of Program Participant Other

Sponsor/Host Organization Name:

Sponsor/Host Email: Sponsor/Host Phone:

Are you currently in the U.S.? (Check appropriate box and answer the questions below)

NO When will you arrive? month/day/year

YES When did you arrive? month/day/year

Have you had Gateway insurance as a Primary Insured or a dependent since your arrival date? No Yes Certificate#

Have you had other insurance as a Primary Insured or a dependent since your arrival date? No Yes If yes, provide:

Insurance Company Name

Request Effective Date and Term of Insurance

Begin my insurance on and continue for 15 Days only OR Months (15 days minimum, 12 months maximum)

U.S. Mailing Address (Insurance coverage documents and renewal notices, if applicable, are mailed here):

c/o Contact Name

Organization Name (if applicable)

Address

City State Zip Code

Contact Information

Day Phone Fax

Email

Accidental Death & Dismemberment Benefit - Loss of Life

Beneficiary Name: Relationship:

If there is no designated beneficiary or the designated beneficiary is not living after the Primary Insured's death, the AD&D benefits will be paid in equal shares to the survivors in the first surviving class of those that follow: the Primary Insured's (1) spouse; (2) children; (3) parents; or (4) brothers and sisters.



Calculating Your Premium

Select Medical Expense Maximum: [ ] Plan A: \$50,000 OR [ ] Plan B: \$100,000

Names of person(s) to be insured

Form with columns: Last Name, First Name, Date of Birth, Enter Premium Rates from Chart. Rows for Primary Insured, Spouse, and multiple Children.

Optional Benefit: \$100,000 Additional AD&D \$ \_\_\_\_\_ X \_\_\_\_\_ = \$ \_\_\_\_\_
Enter Premium Rate From Chart # of Adults on Application
Base Premium \$ \_\_\_\_\_
Multiply by Number of Months\* x \_\_\_\_\_
\*(Only whole numbers, no fractions of months. If 15 Day Plan, enter 1 here)
Total Premium Due \$ \_\_\_\_\_

Premium Rates Per Person

Table with columns: Medical Expense Maximum, Plan A: \$50,000, Plan B: \$100,000. Rows for Adult Rates by Age (18-29 to 80 and over) and Child Rates (for child(ren) under age 18).

Statement of Acknowledgment

Premium, Eligibility Criteria, and Plan Provisions including Limitations and Exclusions are subject to change. Coverage is issued according to plan specifications and rates in effect at time of Application.

The Insurance Company of the State of Pennsylvania (the Insurer), a member of American International Group, Inc. (AIG) insures this Plan. Marsh Affinity Group Services (Marsh), a service of Seabury & Smith, provides insurance program management services for the Plan on behalf of the Insurer and does not represent you or your organization as insurance agent or broker in connection with this insurance transaction.

I acknowledge that I have read, understand, and agree to the terms and conditions of this insurance coverage as it has been presented to me in this brochure.

Signature of Primary Insured or Other Third Party (Required) \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ month/day/year

Method of Payment
Total premium due for the Term of Insurance requested must be paid in U.S. dollars at the time of Application.
Purchase by credit card is subject to validation and acceptance by credit card company.
[ ] Check [ ] Money Order [ ] American Express [ ] MasterCard [ ] Visa
Card# \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_ month/year
Name on Card \_\_\_\_\_
Cardholder's Email \_\_\_\_\_
Daytime Phone \_\_\_\_\_
My signature authorizes the Gateway Plan Administrator to charge my credit card (if selected above) for the total premium due for the Term of Insurance requested.
Signature of Cardholder \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ month/day/year
(Required if Paying by Credit Card)

How To Apply
Print, sign and date the completed Application form. Submit with premium payment to the Gateway Plan Administrator.
Payment by Credit Card
Fax Application form to 202-367-5076 or mail to address shown below.
Payment by Check
Make check or money order payable to Gateway Plan Administrator and mail with Application form.
Mailing Address:
Gateway Plan Administrator
1255 23rd Street, N.W., Suite 300
Washington, DC 20037