INDIA NETWORK SERVICES
INDIA NETWORK HEALTH PREMIER INSURANCE ENROLLMENT FORM
Underwritten by AXIS a US-based insurance company
Fax the completed form to: 800-490-9678

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____ Country _____

Home Phone_____ Work Phone _____

Passport Number: _____ Birth Date (mm/dd/yy) _____ Gender: _____

Home Country: _____ Host Country: _____Arrival Date: _____

E-mail Address: _____

List Dependents to be insured below (IF ANY). Dependent coverage is available only if a parent/spouse is also insured.

Relation	Last Name	First Name	Date of Birth
Spouse			
Child1			
Child2			

Payment Instructions: Consult the chart for premiums and make check or money order made payable to 'India Network Services' in US Dollars. Mail this enrollment form with the premium payment to India Network, 7065 Westpointe Blvd, Suite 209, Orlando, FL 32835 or fax to 800-490-9678 if paying by credit card.

Policy Maximum

[ ] $25,000	**[ ] $50,000**	**[ ] $75,000**
[ ] $100,000	**[ ] $150,000**	**[ ] $250,000**

Choose Pre-existing Deductible

[ ] $75	**[ ] $250**	**[ ] $500**
[ ] $1,000	**[ ] $5,000**	**[ ] $10,000**

Payment Information: I am enclosing a check for $ _____ Or

I hereby authorize charge of Total Premium $_____(Calculate from the Website or call our office)

Credit card # (MC/VISA/AMEX/DISC) _____ Exp. Date:___/___ Vcode: _____

Cardholder's Signature _____ Date ___/___/___

PERIODS OF COVERAGE: I want my coverage to begin on _____/_____/_____ and end coverage on _____/_____/ _____ (mm/dd/yy.

Important: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Coverage will be effective on the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. It is the Insured's responsibility to timely submit renewal payments. By signing below, the visitor acknowledges the following: (1) He/She has carefully read, understands, and agrees to the terms and conditions of the coverage including the pre-existing condition limitations and elects to enroll as indicated on this enrollment form; (2) Rates are not prorated other than as listed on this enrollment form; (3) He/She meets the eligibility requirements for this coverage as described in the program description; (4) if it is later determined that the visitor is not eligible, the premium will be refunded; and (5) I have read, understood and agree with the cancellation policy that no refunds after effective date.

Signature of Enrollee: _____ Date _____/_____/_____
(Or Person completing the form)

Name of the India Network Member:_____

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