INDIA NETWORK HEALTH INSURANCE RENEWAL FORM
Underwritten By CHUBB AMERICAN INSURANCE COMPANY

Please fax the completed to: 800-490-9678

General Information of the Insured (Use Separate forms for 2-17,18-49, 50-69,70-79, and 80+)

Name (Last, First, MI):		
DOB (mm/dd/yy)		Passport #:
Home Phone:		Office Phone:
E-mail:		

List Dependents to be insured below. Dependent coverage is available only if the Visitor is also insured.

Last Name	First Name	Date of Birth (mm/dd/yy)	Passport Number

Payment Instructions: Determine premium and make check or money order made payable to India Network Services in US Dollars. Mail the form and payment check to **INDIA NETWORK SERVICES, 7065 Westpointe Blvd, Suite 209, Orlando, FL 32835** or furnish the credit card information below.

Check One Box per Line Below:
Coverage Requested: [ ] $50,000 Max [ ] $100,000 Max [ ] $150,000 Max
Deductible Requested: [ ] $75 (2-69 Yrs) [ ] $250 (for all ages) [ ] $500 (only for 70+)

Pre-existing Coverage Rider: [ ] Yes [ ] No
Pre-existing Condition Deductible: [ ] $1,000 [ ] $5,000

PERIODS OF COVERAGE

I want to renew coverage from the date (mm/dd/yy) ____/____/____ TO ____/____/____

I hereby authorize charge/enclose check for Total Premium $_____ (=Premium per month X NUMBER of months + $5 admin fee) to my Credit Card (MC/Visa) number given below:

CC Number (MC/VISA): ______________________ Exp. Date ___/___ Vcode: __________

Cardholder’s Signature_____________________________ Date ___/___/___

Important: Coverage will be effective 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 Visitor’s responsibility for timely renewal. By signing below, the Visitor acknowledges the following: (1) He/She has carefully read, understand, 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 possible after effective date.

Signature of Person Completing: ____________________________ Date ____/____/____

Member's Name and Relationship: _____________________________________

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