

# PATRIOT T.R.I.P.® STUDENT GROUP APPLICATION

1. Complete this entire Application.
2. If paying by check or money order, please make payable to iTravelInsured and enclose in envelope with signed Application.
3. Mail or fax completed Application to: iTravelInsured, P.O. Box 88503, Indianapolis, Indiana 46208-0503 USA Fax 317-655-4505.

Date of Departure \_\_\_\_\_ Date of Return \_\_\_\_\_

*\*Note: Patriot T.R.I.P. Student is designed for trips of 30 days or less, the trip cost is subject to a \$300 minimum and coverage is available up to \$5,000. This plan is offered only to students who are 25 years of age or younger during the covered trip.*

Contact Information (please print)  Mr.  Mrs.  Ms.

Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Name of School, Camp or Group, if applicable: \_\_\_\_\_

Address \_\_\_\_\_

City, State, Country, Zip \_\_\_\_\_

Email address \_\_\_\_\_

Phone \_\_\_\_\_

Name of traveler (last, first)	Birth Year	Country of Citizenship	Program Cost Calculation		Cost
			Current year - Birth year = Total years	\$ _____ X .0253 = Cost of trip Rate factor	
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**MEMBERSHIP** I (we) hereby apply for membership to the National Small Business Travel and Health Association.

**CERTIFICATION** I (we) hereby certify and represent that I (we) have read, or have had read to me (us), all statements and answers recorded on this application. They are true, complete and correctly recorded. I (we) confirm that all travelers listed on this application are medically able to travel on the date this coverage is purchased. I (we) understand and agree that subject to the acceptance of this application and payment of the program cost in full, coverage will begin at 12:01 a.m. on the day after this completed application is received.

**X Signature of Applicant or Proxy** \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_

**Payment Method**  Check (To iTravelInsured)  
 Money Order (To iTravelInsured)  Mastercard  Visa  
 American Express  JCB  Discover

*If paying by credit card, I authorize iTravelInsured to debit my credit card account for the total charge as specified in Total Program Cost. Coverage purchased by credit card is subject to validation and acceptance by credit card company. I agree to comply with the cardholder agreement.*

Card# \_\_\_\_\_ Expiration date \_\_\_\_\_

Name on Card \_\_\_\_\_

Signature \_\_\_\_\_

Your Daytime Phone \_\_\_\_\_

Your Billing Address \_\_\_\_\_

\_\_\_\_\_

**Total Program Cost**

Producer# 10550  
 GA# \_\_\_\_\_  
 Name \_\_\_\_\_  
 Address 301 EAST 66  
 ST. JET,  
 City, State, Zip NEW YORK  
 NY 10065  
 Phone: 617-964-4849