

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.

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 _____

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.*

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 **SENBERG ASSOCIA**
 Address 1330 CENTRE ST.
 City, State, Zip **NEWTON CENTI**
MA 02459
 Phone: 617-964-4849