

ROUNDRIP ENROLLMENT FORM

July 1, 2002



Producer # 1009 www.otis123.com
805-531-9200 or

Toll Free 1-866-OTIS123

Protection Plan may be purchased if you are a resident of the United States or if you purchase this plan within the United States.

Applicant Information

(First Name – Middle Name – Last Name)

Primary Applicant: _____

Birth Date (MM/DD/YYYY): ____ / ____ / ____

Spouse: _____

Birth Date (MM/DD/YYYY): ____ / ____ / ____

Dependent Child: _____

(under 19 years of age)

Birth Date (MM/DD/YYYY): ____ / ____ / ____

Dependent Child: _____

(under 19 years of age)

Birth Date (MM/DD/YYYY): ____ / ____ / ____

Trip Information

Departure Date (MM/DD/YYYY): ____ / ____ / ____

Return Date (MM/DD/YYYY): ____ / ____ / ____

Destination: _____

Name of Travel Supplier: _____
(Airline, Tour Operator, Cruise Line, etc.)

Personal Information

Your Address: _____

(must be a U.S. address)

City / State / Zip: _____

Phone: (____) _____ Fax: (____) _____

Beneficiary: _____
(For AD&D and optional Flight Accident Coverage)

In Florida, Florida Resident – Agent No. A269211

Fax Application to: 805-531-1161

Rate Calculation

Plan must be purchased for the FULL cost of trip. See rates (pg. 7).

	Trip Cost	Plan Cost*
Primary	\$ _____	= \$ _____
Spouse	\$ _____	= \$ _____
Dependent Child	\$ _____	= \$ _____
Dependent Child	\$ _____	= \$ _____

* Plan costs must be indicated for all travelers.

For Trips of 31 – 90 Days. Include departure & return dates in calculation.

$$\$3 \times \frac{\text{# of Days Over 30}}{\text{Total # of Travelers}} = \$ \underline{\hspace{2cm}}$$

Optional Flight Coverage (Maximum \$100,000 / person)

$$\$100,000 \text{ Protection for } \$10 \times \frac{\text{Total # of Travelers}}{\text{Total # of Travelers}} = \$ \underline{\hspace{2cm}}$$

Non-Refundable Processing Fee = \$ 5.00

Total Amount Due = \$ _____
And authorized as payment below.

Method of Payment

- Check / Money Order Payable to SRI
 Visa MasterCard Discover/Novus Diners Club
Signature is required below for all methods of payment.

CC Number: _____

Expiration Date: _____ Daytime Phone: _____

Name on Card: _____

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. Plan costs are non-refundable after 10-day review period.

Signature: _____ Date _____