HUDSON HENDERSON INSURANCE BROKERS LTD.

AIG Travel Guard

Emergency Medical Travel Insurance

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments.

Application

Sports Teams

11 Cameron St. West, P.O. Box 520
Cannington, Ontario L0E 1E0
Tel: (705)432-2314 or 1-877-682-0022
Email: bill@wledwards.com
Please Complete and fax to: (705)432-2819

Team Name:

Contact Last Name: First Name:

Team Address: Apt:

City: Province: Postal Code:

Phone Number: Fax Number: E-mail:

Trip Information and Premium Calculation

Destination: | Departure Date: (DD/MMM/YYYY) / / | Return Date: (DD/MM/YYYY) / /

			I Ages 0 – 29*	II Ages 30-59*	III Ages 60-64*	IV Ages 65-69*	V Ages 70-74*
a)	Rate	Days 1 - 60	$1.25	$1.70	$5.00	$7.25	$11.00
		Days 61 - 365	$1.35	$1.95	N/A	N/A	N/A
b)	Total trip duration (# of days):						
c)	Total number of applicants:						
d)	Premium (a x b x c):		$.	$.	$.	$.	$.

Total premium from line d (I+II+III+IV+V) $.

Method of Payment

__ Cheque or money order (made payable to Hudson Henderson Insurance Brokers Inc.)

Note: If you are paying by cheque or money order, please send the completed application by mail with your payment enclosed to the address above. To ensure your application is processed quickly, supply the credit card information indicated below and return the completed application by fax or email.

__ Master Card __ American Express __ Visa __ Diners-EnRoute

Credit Card Number: / / / / / / / / / / / / / / / Expiry Date: (MM/YY) /

I hereby authorize release of any information, including medical records that are needed to process a claim filed under this policy, in conjunction with the purchase of this policy, to American Home Assurance Company (AIG), Travel Guard Canada, or its representatives.

This signatory confirms that every person named on this application is in good health and knows of no reason to seek medical attention. Applicants are aware that if they have any condition affecting their health that claims relating to this condition may be excluded under this policy.

Cardholder's Signature: (DD/MM/YYYY)

For Office Use Only

Date Issued (DD/MM/YYYY): Policy Number:

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Please Complete and fax to: (705)432-2819

Team Name:

Last Name	First Name	Date of Birth (DD/MM/YYYY)	Sex		Province of Residence
1.			F	M	
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