

**INDIA NETWORK HEALTH INSURANCE RENEWAL FORM**  
**Underwritten By the Insurance Company of the State of Pennsylvania**

Please fax the completed to: 407-479-3289

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 GLB9124104/9124105/9124106. 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: \_\_\_\_\_