INDIA NETWORK HEALTH INSURANCE
ACCIDENTAL DEATH and DISMEMBERMENT ENROLLMENT FORM
Underwritten By ACE American Insurance
Fax the completed form to: 407-479-3289

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____ Country _____

Home Phone_____ Work Phone _____

Passport Number: _____ Birth Date (mm/dd/yy) _____ Gender: _____

Home Country: _____ Host Country: _____

E-mail Address: _____

Beneficiary Information:

Last Name	First Name	Address	Relationship

Payment Instructions: Choose a plan and make check or money order payable to 'India Network Services' in US Dollars. Mail this enrollment form with the premium payment to India Network, 7065 Westpointe Blvd, Suite 209, Orlando, FL 32835 or fax to 407-479-3289 if paying by credit card.

Choose Plan:
[ ] $23 per year ($25,000 Benefits) per person (0-69)
[ ] $41 per year ($50,000 Benefits) per person (0-69)
[ ] $77 per year ($100,000 Benefits) per person (0-69)

NOTE: Your membership fee is already added to the plan.

Payment Information: I am enclosing a check for $ _____ Or

I hereby authorize charge of Total Premium $_____

Credit Card # _____Exp. Date (MM/YY):___/___ Vcode: _____
(MC/VISA/AMEX/DISC)

Cardholder's Signature: _____ Date: ___/___/___

Important: By signing below, the AD&D insurance enrollee acknowledges the following: (1) He/She has carefully read, understands, and agrees to the terms and conditions of the coverage limitations and elects to enroll as indicated on this enrollment form; (2) He/She meets the eligibility requirements for this coverage as described in the program description; and (3) He/She have read, understood and agree with the cancellation policy that no refunds after effective date.

Signature of Enrollee: _____ Date ____/____/____
(Or Person completing the form)

Name of the India Network Member: _____