INSURANCE APPLICATION FORM
Special Visa Program
Standard Freedom Plan (Non-ACA)

Use this Application Form to apply for coverage under the Standard Freedom Plan (Non-ACA). Please fill out this form completely (incomplete forms will cause a delay in processing). The person to be covered must have a valid G Visa or A Visa (for example, G5, G4, A3, or another type of G or A Visa).

Coverage begins on the later of November 1, 2016 or the first day of the month following the date you submit this Application Form and Bank Authorization Form, provided your application is approved by WellAway, Ltd.

Mail or email this form along with a copy of the applicant/insured's Visa and dependent(s)' Visa to:

Safe Passage International, LLC
3609 S. Wadsworth Blvd., Suite 565, Lakewood, CO 80235
Tel: 303-988-9626 x117, or Toll Free: 1-800-777-7665 x117
Fax: 720-504-3735 Email: Visa@spibrokers.com
Website: www.spibrokers.com/Visa

(Please type or print legibly)

Employer/Sponsor _____

First M. Last

Agency Name _____ Agency ID # _____

Home Address in USA

_____

Street City State Zip Code

Home Phone (____) _____ Office Phone (____) _____ Email:_____

Applicant/Insured _____ Date of Birth _____

First M. Last

Applicant/Insured VISA # _____ VISA type _____ Sex _____

Male or Female

Home Country _____ Smoker ❑ Nonsmoker ❑

The applicant is applying for coverage under the following Standard Freedom (non-ACA) Plan (check one):

- ❑ **Plan A**
- ❑ **Plan B**
- ❑ **Plan C**

Attach a copy of the Applicant/Insured's current VISA to this application.

To apply for Dependent coverage under this insurance plan, please complete Page 3.

We have read the Benefit Summary for the Standard Freedom Plan (Non-ACA), and agree to its terms and conditions:

Signed (Employer/Sponsor) _____ Date _____

Signed (Applicant/Insured) _____ Date _____

DEPENDENTS

Dependent #1 Name _____ Date of Birth _____

First *M.* *Last*

Home Address in USA

_____

Street *City* *State* *Zip Code*

Relationship to Applicant/Insured _____

Dependent VISA # _____ VISA type _____ Sex _____

Male or Female

Home Country _____ Smoker ❑ Nonsmoker ❑

Attach a copy of this Dependent's current VISA to this application.

Dependent #2 Name _____ Date of Birth _____

First *M.* *Last*

Home Address in USA

_____

Street *City* *State* *Zip Code*

Relationship to Applicant/Insured _____

Dependent VISA # _____ VISA type _____ Sex _____

Male or Female

Home Country _____ Smoker ❑ Nonsmoker ❑

Attach a copy of this Dependent's current VISA to this application.

Dependent #3 Name _____ Date of Birth _____

First *M.* *Last*

Home Address in USA

_____

Street *City* *State* *Zip Code*

Relationship to Applicant/Insured _____

Dependent VISA # _____ VISA type _____ Sex _____

Male or Female

Home Country _____ Smoker ❑ Nonsmoker ❑

Attach a copy of this Dependent's current VISA to this application.

AUTHORIZATION AGREEMENT
FOR AUTOMATIC DEBITS (A.C.H. DEBITS)
Special Visa Program Insurance Plan
Standard Freedom Plan (Non-ACA)

Use this Authorization Agreement to initiate recurring automatic deductions from your bank account to pay the monthly cost of the Standard Freedom (Non-ACA) Insurance Plan indicated on your Insurance Application Form. Bank Account deductions will occur on the 5th of every month. You can also pay your premium by check or money order. Credit card payments are not accepted.

Please fill out this form completely.

Mail or email the completed form to:

Safe Passage International, LLC
3609 S. Wadsworth Blvd., Suite 565
Lakewood, CO 80235
Tel: 303-988-9626 x117, or Toll Free: 1-800-777-7665 x117
Fax: 720-504-3735 Email: Visa@spibrokers.com
Website: www.spibrokers.com/Visa

(Please type or print legibly)

Employer/Sponsor _____
First *M.* *Last*

Applicant/Insured _____
First *M.* *Last*

I (we) hereby authorize Safe Passage International, LLC, hereinafter called the Program Manager, on behalf of WellAway, Ltd., to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit to my (our) bank account as indicated below, hereinafter called the Originating Bank, to credit and/or debit the same to such account.

Originating Bank Name: _____

City _____ Zip Code _____

Routing/ABA # _____

Account # _____ Account Type: Checking ❑ Savings ❑

This Authority shall remain in full force and effect until the Administrator has received written notification from me (or either of us) to its termination in such time and in such manner as to afford the Administrator and Originating Bank a reasonable opportunity to act on it.

Bank Account Owner's Name _____
(Please Print)

Owner's Signature: _____ Date _____