



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 first day of the month following the date you submit this Application Form, Bank Authorization Form, and a copy of the USA Visa for the person to be insured, provided your application is approved by WellAway, Ltd.

Email this form along with a copy of the applicant/insured's Visa and dependent(s)' Visa to Safe Passage International at Visa@spibrokers.com.

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 # _____

Employer/Sponsor Home Address in USA

Street City State Zip Code
Home Phone () _____ Office Phone () _____ Email: _____

Applicant/Insured _____ Date of Birth _____
First M. Last

Applicant/Insured Address in the USA (if different from Employer)

Street City State Zip Code
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 (Non-ACA) Plan**, 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) Plan** indicated on your Insurance Application Form. Bank Account deductions will occur on the 4th of every month. Credit card payments are not accepted.

Please fill out this form completely and email back to us at Visa@spibrokers.com.

Safe Passage International, LLC
3609 S. Wadsworth Blvd., Suite 565
Lakewood, CO 80235
Tel: 1-800-777-7665 x117
Website: www.spibrokers.com/Visa
Email: visa@spibrokers.com

(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 _____