

# Application- Liaison Traveler

OFFICIAL USE ONLY: Cert#: \_\_\_\_\_ Processed: \_\_\_\_\_ Eff Date: \_\_\_\_\_ Agent: 7076

## Applicant Information

Mr.  Mrs.  Miss  Ms  
Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ MI \_\_\_\_\_  
Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ (month/day/year)  
Passport Number: \_\_\_\_\_  
Issuing Country: \_\_\_\_\_

What do you consider your Home Country?  
\_\_\_\_\_

## Address of Correspondence

Address: \_\_\_\_\_  
\_\_\_\_\_  
City/State: \_\_\_\_\_  
Postal Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_  
Work phone ( ) \_\_\_\_\_ Home phone ( ) \_\_\_\_\_  
Email Address \_\_\_\_\_

## For AD&D benefit...

Beneficiary \_\_\_\_\_  
Relationship \_\_\_\_\_

## For Couple or Family Coverage...

Names of additional persons to be insured?	Date of Birth
Spouse _____	___ / ___ / ___
Child _____	___ / ___ / ___
Child _____	___ / ___ / ___
Child _____	___ / ___ / ___
Child _____	___ / ___ / ___

(please attach separate sheet for additional children)

Have you purchased insurance through SRI before?

Yes  No

If yes, when? From \_\_\_\_\_ to \_\_\_\_\_

Requested Effective Date of coverage:

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

\*Note: Coverage cannot begin until SRI receives your application and correct premium.

## Calculating Your Premium

Select Policy Period:  3-Months  6-Months  12-Months

Select Plan Type:  Single (applicant only)  Couple  Family  
(Be sure to use correct premium)

Premium

Standard Program \$ \_\_\_\_\_

### Standard Upgrade Options (if applicable)

Increase AD&D to: \$ \_\_\_\_\_ \$ \_\_\_\_\_

### Personal Liability Program

(The U.S. must be your Home Country)  
(Not available to Oregon residents)

\$ \_\_\_\_\_

Plus Admin Fee: \$ 10.00

Total Payment Enclosed: \$ \_\_\_\_\_

## Method of Payment

Check  Money Order  MasterCard  Visa  Discover  
Card# \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Name as it appears on card \_\_\_\_\_

Signature (required) \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

Only one Liaison Traveler program may be purchased for any given policy period. Make Check or Money Order payable to: "SRI". Total Payment for the Full Term of coverage requested must be paid in U.S. dollars at the time application for coverage is made. Coverage purchased by credit card is subject to validation and acceptance by credit card company. I declare that I understand the terms and conditions of this product, as outlined in this brochure. I hereby subscribe to the AIG Life Trust and enroll in the group coverage for which I am eligible under the group contract issued by The Insurance Company of the State of Pennsylvania, a member of American International Group, Inc. (AIG).

Signature of Insured or Proxy \_\_\_\_\_

Date (required) \_\_\_\_\_