Corporate Annual Plan

SPREZZATURA
Insurance Group, LLC

Travel Insurance Protection Plan
ENROLLMENT FORM

INSURED:

DR. ___ MR. ___ MRS. ___ MS. ___ *M ___ F ___

*LAST: _____ *MI: _____ FIRST: _____

*DATE OF BIRTH: _____ EMAIL: _____

*ADDRESS: _____

*CITY: _____ *STATE: _____ *ZIP: _____

*PHONE: _____ BENEFICIARY: _____

AGENCY ARC NO. _____ AGENT ID NO.: _____

* REQUIRED INFORMATION

Any person who knowingly and with intent defrauds any insurance company is subject to criminal and civil penalties. I represent that the above information is true and the dates reflect my intent to start and end my trip. The coverage goes into effect after the premium is paid, at 12:01 a.m. on the day after the postmark, telephone purchase, fax transmission date, or online pur- chase confirmation date. The Insurer reserves the right to reject any Enrollment Form. I under- stand there is no coverage for loss due to pre-existing medical conditions, unless this insurance is purchased within the required time frame to waive this exclusion. I understand that if payment is returned unpayable for any reason, the coverage becomes null and void. I also understand that any changes to this Enrollment Form do not change the coverage of the policy. I have read, understand, and agree to the terms and conditions of the Insurance as detailed in the Description of Coverage.

Plan Cost / $160

Payment information

___ CHECK OR MONEY ORDER PAYABLE TO **SPREZZATURA INSURANCE GROUP,LLC**

___ AMERICAN EXPRESS® ___ MASTERCARD ___ VISA ___ DISCOVER / NOVUS

EXPIRES: ____/____/____

NAME OF CARDHOLDER: _____

_____ _____

SIGNATURE DATE

4810 NW 74th Avenue Miami, FL 33166 • Phone: **(305) 482-9611** • Fax: **(305) 499-9670** • www.**sprinsgroup**.com