PACIFIC CROSS

PREMIER INTERNATIONAL PLAN

2026

Injury & illness are never by choice
Your health insurance can be!

INTRODUCTION & BENEFITS SCHEDULE

The Premier International Plan offers solid benefits at affordable prices. Choose from a range of additional benefits and discount options and customize the plan to meet your needs.

Schedule of Benefits (in US$)

	PREMIER 250	PREMIER 500
Maximum Limit per Policy Year	US$250,000	US$500,000

Covers normal, usual and customary charges for:

Inpatient Benefits

Room and Board	Private in ASEAN countries Semi-private elsewhere	
Parent Accommodation An extra bed in the same room for a parent accompanying an insured child under 12 years old	100%	
Intensive Care Unit, Coronary Care Unit and Operating Room	100%	
Surgeon's Fee Includes pre-surgical assessment and normal post-surgical care	US$30,000	100%
Anaesthetist's Fee	35% of eligible Surgeon's Fee	100%
Miscellaneous Inpatient Charges For required diagnostic laboratory tests, x-rays, prescribed medicines; Professional Fees; blood and plasma; kidney dialysis; wheelchair rentals; outpatient surgery; surgical appliances and devices; and intra-operative standard prosthetics (as approved by the Company); and any types of lenses up to US$800 following cataract surgery	100%	
Organ Transplant Fees for kidney, heart, lung or liver transplants (up to 50% for donor and the remaining percentages for recipient, at the option of the Insured Person) to a total of This benefit is a lump sum maximum per organ and no other policy benefits such as expenses for regular medical care or consultation, diagnostic tests and long-term medication are payable in respect of Organ Transplant	US$37,500	US$75,000
HIV / AIDS Coverage will apply when HIV and/or its related illnesses present for the first time after 5 years continuous coverage under the Policy and any renewal thereof, with lifetime limit of	US$25,000	US$50,000
Hospital Cash Benefit For inpatient treatment received without charge for up to 15 nights	US$100 per night	
Home Nursing Immediately after a hospital confinement and certified to be medically necessary by the attending physician for up to 45 days	100%	
Rehabilitation When certified necessary by the attending physician for up to 45 days of inpatient, day case or outpatient treatment starting within 14 days immediately after the hospitalization	100%	
Oncology Radiotherapy, Chemotherapy, targeted therapy, immunotherapy, hormonal therapy (by way of infusion, injection or oral medications), and fees for bone marrow transplant and peripheral stem cell transplants when treating cancer with or without high dose chemotherapy received as inpatient, day case or outpatient treatments subject to a maximum limit of US$5,000 for oral medications Oncology treatment must be received as an inpatient or outpatient at a hospital, or at an oncology day case center within a hospital, or at a cancer treatment center licensed by the relevant health authority or accredited by an internationally recognized oncology body	100%	
Hospice Care For terminal illnesses with lifetime limit of	US$25,000	
Psychiatric and Mental Disorders Hospital charges of US$50,000 per year with lifetime limit of	US$125,000	
Maternity Benefit Maximum limit per pregnancy after a 12-month waiting period (90 days for miscarriage and therapeutic abortion) up to When both parents are insured, the limit shall be increased by 50%	US$2,500	US$3,750
Free New Born Child Coverage New born child is eligible for the same medical plan as the Insured Person 15 days after the later of the date of birth or the date of discharge on submission of application to the Company until the Insured Person's next renewal for free.	Included	

Emergency Benefits

Emergency Room Treatment	100%
Accidental Damage to Teeth Emergency treatment for up to 7 days following accidental loss or damage caused to sound natural teeth	100%
Emergency Local Ambulance Service	100%
Emergency Assistance Services	Included
Repatriation of Mortal Remains Covers costs for repatriation of mortal remains of the Insured Person to home country or country of residence	100%

INTRODUCTION & BENEFITS SCHEDULE

	PREMIER 250	PREMIER 500
Outpatient Benefits		
Physician and specialists' fees for office visits - Physiotherapist and chiropractor when referred by the attending physician; and for required diagnostic laboratory tests, x-rays and prescribed medicines	100%	
Alternative Medicines Fees for visits to homeopath, osteopath, podiatrist, acupuncturist, bonesetter, herbalist and Chinese medicine practitioner; and prescribed herbs up to an annual limit of	US$250/year	US$500/year
Medical Check-up and Vaccinations Annual limit for routine medical check-ups and vaccinations	US$350	

Note: "100%" herein means full reimbursement of the normal, usual and customary charges in accordance with the eligible room type or other localized circumstances or customs.

Additional Benefits	
Covers normal, usual and customary charges for eligible expenses:	
Dental Benefit 80% reimbursement up to an annual limit of	US$2,000
Personal Accident Benefit Covers loss of life, loss of one or both hands or feet, loss of vision in one or both eyes, or permanent and total disability caused directly and solely by an accident. (Maximum benefit is US$100,000 after age 65 and coverage is terminated after age 80. Child benefit limit is 10% of the sum insured of his parent/guardian subject to the maximum of US$50,000)	US$100,000 to US$500,000
Travel Benefit Covers the following eligible expenses worldwide when travelling outside your country of residence on trips lasting up to 90 days:	
Emergency Medical Expenses - Covers illness or injury including "Emergency Evacuation" - (up to US$25,000) with a maximum of US$300 per day for hospital room and board if the hospital expense is on per diem basis, a daily reimbursement of all charges inclusive of room and board and professional services is limited to US$1,000 if no detailed breakdown of charges is provided; and "Medical Repatriation" – covers the additional cost of your own travel necessarily incurred as a result of a covered disability to get you back home following Emergency Evacuation.	US$35,000
Baggage & Travel Documents Covers loss and damage of baggage and personal items including laptop computer; and loss of travel documents up to	US$750
Baggage Delay Covers purchase of essential clothing and toiletries if your checked baggage is delayed on arrival at your destination for over 12 hours up to	US$125
Personal Money Covers theft, burglary and robbery of cash, bank notes and travellers checks up to	US$500
Hospital Cash Income Pays US$50 per day for each day you are hospitalized over 24 hours up to	US$600
Travel Delay Covers transportation expenses incurred as a direct consequence of travel delay resulting from serious weather conditions, natural disasters (earthquake, flood, hurricane, tornado, tsunami, etc.), industrial action, hijack, mechanical derangement if an Insured Person has to re-route his trip due to cancellation of a prior confirmed booking; or "Cash Allowance" - pays US$25 for each full 6 hours delay up to a maximum of US$100	US$650
Curtailment of Trip & Cancellation Charges Covers irrecoverable prepaid travel arrangement deposits or any increased cost of travel in the event of death, serious injury or illness of the Insured Person, immediate family members or close business partner or travel companion of the Insured Person, witness summons, jury service, compulsory quarantine; natural disasters at the planned destination or complete destruction of the Insured Person's principal residence.	US$2,500
Optional Rental Car Protection Covers loss and damage which occurs to a rental car result directly from fire, theft, collision or vandalism. Deductible: US$500	US$10,000
Discount Options	
(Not applicable to Additional Benefits and subject to US$200 minimum per Insured Person)	
Treatment Area Limit (TAL) When selected by the policyholder in respect of the policy provides coverage in Hong Kong (SAR), Japan, North America and Singapore provided the Insured Person has not been travelling to these locations for more than 30 accumulated days in one policy year. The coverage is for inpatient treatment in the event of an emergency resulting from an accident and/or the onset of an acute disability which the Insured Person had not suffered from or had been symptomatic prior to travelling.	25% Discount
Outpatient Exclusion (excludes outpatient coverage)	25% Discount
20% Co-payment (you pay 20% and we pay 80% of eligible expenses)	25% Discount
Group Discount	
(Not applicable to Additional Benefits)	
5+ persons	10% Discount
21+ persons	20% Discount

PREMIUM TABLES & KEY FEATURES

Premium for Premier 250 Plan (in US$)

Age Band	0-3	4-18	19-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	86-90
Worldwide	2,321	1,824	2,663	2,866	3,098	3,312	3,744	4,156	4,831	5,727	7,472	10,772	15,123	20,162	28,538	37,150
TAL*	1,741	1,368	1,997	2,150	2,324	2,484	2,808	3,117	3,623	4,295	5,604	8,079	11,342	15,122	21,404	27,863

Premium for Premier 500 Plan (in US$)

Age Band	0-3	4-18	19-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	86-90
Worldwide	2,409	1,893	3,172	3,411	3,682	3,939	4,385	4,910	5,767	6,831	8,916	12,849	18,042	24,056	34,048	44,324
TAL*	1,807	1,420	2,379	2,558	2,762	2,954	3,289	3,683	4,325	5,123	6,687	9,637	13,532	18,042	25,536	33,243

***TAL option** (Treatment Area Limit) is available to residents in Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Taiwan, Thailand, and Vietnam. TAL limits coverage in Hong Kong (SAR), Japan, North America and Singapore to Emergency Inpatient cover for accumulated 30 days per policy year (For full details please refer to Policy Wording).

Residents in the E.U. Countries, U.K. and Switzerland (20% loading to Worldwide Premium).
Residents in Singapore (40% loading to Worldwide Premium).
Residents in Hong Kong (40% loading to Worldwide Premium).
Geographical loading for North American residents is available on request.

****Medical Examination Requirement.** Applicants over the age of 65 must at their own expense have a Company approved physician submit a completed Physician Examination Report directly to the Company.

Medical Second Opinion

There are times when a second medical opinion is better than relying on one. A Medical Second Opinion is available for eligible medical conditions and accidents and will assess whether the original treatment is in line with state-of-the-art medicine and meets your needs. With this second opinion, you can see more clearly and take serious and far-reaching decisions on the basis of the best information.

Premium for Additional Benefits (in US$)

Age Band	0-3	4-18	19-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	86-90
Dental	781	781	781	781	781	781	781	781	781	781	781	781	781	781	781	781
Travel	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88
Rental Car Protection	Not available			83 (Age 23 to 75)										Not available		
Personal Accident	Class 1 Occupation -US$1 per 1,000 Class 2 Occupation -US$1.25 per 1,000														Not available	

No Claim Discount
A No Claim Discount will be offered to Insured Persons who are not entitled to Group Discount and have been insured for a period of not less than 12 months. While an Insured Person's plan remains claims-free at each renewal, the following No Claim Discount will be applied:

Year 0	Year 1	Year 2
No discount	10% discount	15% discount (maximum cap effective April 1, 2026)

If a claim is made by an Insured Person during a policy year, any No Claim Discount achieved will be lost and the status of the discount will be as at Year 0 shown above. The No Claim Discount applies only to the premium in respect of the basic benefits. Claims against any Additional Benefit Plans (Dental, Vision, Personal Accident and Travel Plans) and Medical Check-up and Vaccinations will not affect the No Claim Discount.

Key Features

Free Choice of doctors and hospitals.
Guaranteed renewability regardless of age, medical condition or location.
Flexible geographic cover.
Free coverage for recreational sports.
Direct payment to hospitals and 24-hour Worldwide Emergency Assistance.
Consideration of declared pre-existing conditions.

This brochure is not a contract. For exact wording and complete details of the cover, terms, conditions and exclusions of the policy, please refer to the policy itself.

If you have any questions relating to this application, please forward them to Pacific Cross Insurance Company Limited at
E-mail: inquiry@pacificcross.com
Website: http://www.pacificcross.com

The Third Party Administrator for Pacific Cross Insurance Company Limited is International Administrators Limited:
31/F, Times Media Centre, 133 Wan Chai Road,Wan Chai, Hong Kong, SAR
Tel: (852) 2573-2278, (852) 2573-2535; Fax: (852) 2573-2917

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Dental Benefits

A completed Oral Examination Report must be submitted with the first dental claim. All conditions requiring treatment as of the first dental visit are deemed to be pre-existing conditions.

Exclusions

Medical plans do not cover care, treatment, services or supplies for:

- Pre-existing conditions not declared to and accepted by the Company;
- Which the Insured Person is entitled to indemnity from a third party or other benefit plan;
- Birth control; treatment of impotence or infertility (including artificial insemination, in-vitro fertilization, embryo transfer); sterilization reversal or elective abortion;
- Congenital conditions and genetic deformities or diseases;
- Weight treatment and management or bariatric surgery;
- Developmental abnormalities;
- Persistent Vegetative State or permanent neurological damage;
- Custodial Care, home care or services, routine medical check-ups, or any treatments considered unnecessary by the Company, vaccinations (except for the side effects resulting from receiving the COVID vaccinations), counselling, hearing tests, refractive defects of the eye, corrective eye surgery for refractive error, corrective devices, or dental treatment unless covered under the optional benefits cover of this policy for vision, dental, or medical check-up;
- Disability resulting from war or any act thereof, service in the military, naval or air force, riot, civil commotion;
- Hazardous or professional sports unless declared to and accepted by the Company;
- Intentionally self-inflicted injury, suicide, abuse of alcohol, drug addiction or venereal diseases;
- Cosmetic or reconstructive surgery except otherwise mentioned in the policy document;
- Prosthesis, orthotic devices, corrective devices and medical appliances not required for a surgical operation;
- AIDS, AIDS Related Complex, or Human Immunodeficiency Virus(HIV) and/or related illnesses which manifest at any time within five years from the Insured Person's effective date; and
- Expenses incurred for provision of medical documentation required by the Company.

14-Day Free Look

You may return your policy within fourteen days after receipt for a full refund of the premiums paid.

Free New Born Child Coverage

A child of an Insured Person is eligible for the same medical plan as the Insured Person 15 days after the later of the date of birth or the date of discharge on submission of application to the Company until the Insured Person's next renewal for free.

Child Coverage

A child or children cannot be covered alone under an insurance policy. Parents or guardians must be included in order for a child/children to be insured.

Geographical Loading

Applies to the Medical Plan (& options) premium for residents to cover the high cost of medical care in that particular area.

Maternity Benefit

Expenses are covered where applicable after a 12-month waiting period. Miscarriage, therapeutic abortions, hydatiform mole and etopic pregnancy are covered after 90 days. Benefit shall include all pre-natal and post-natal care, hospital room and board, professional fees (except pediatrician), miscellaneous charges, and up to 7 days of nursery care. When both parents are insured for the same medical plan, the maximum benefit shall be increased by 50%.

No Claim Discount

A No Claim Discount will be offered to Insured Persons who are not entitled to group discount and have been insuring for a period of not less than 12 months. While an Insured Person's plan remains claims-free at each renewal, the following No Claim Discount will be applied:-

Year 0 No discount
Year 1 10% discount
Year 2 15% discount (maximum cap effective April 1, 2026)

If a claim is made by an Insured Person during a policy year, any No Claim Discount achieved will be lost and the status of the discount will be as at Year 0 shown above.

If a claim relating to the previous year is subsequently submitted and accepted, and a No Claim Discount has already been given, the Company reserves the right to deduct the equivalent monetary amount of the No Claim Discount from the value of the claim.

The No Claim Discount applies only to the premium in respect of the basic benefits. Claims against any Additional Benefit Plans (Dental, Vision, Personal Accident and Travel Plans) and Medical Check-up and Vaccinations will not affect the No Claim Discount.

Occupational Class

Personal Accident cover is based on the hazard class associated with an occupation and its duties. Class 1: very light hazards; Class 2: light hazards; Class 3: non-hazardous manual labor; and, Class 4: hazardous occupations. Class 3's are quoted on request and Class 4's have no cover.

Pre-existing Condition

Any Disability which existed before the policy effective date in respect of an Insured Person, which presented signs and symptoms of which the Insured Person was aware or should reasonably have been aware.

Premiums

Are based on the Insured Person's age on the first day of the policy year; the rate table in effect on the premium due date; and, residence, family status, payment mode and other factors which affect the cost of insurance. Premiums may be revised based on claims experience or other criteria which the Company, at its sole discretion, may determine. Policies renew automatically upon payment of renewal premium.

Treatment Area Limit

Does not apply to inpatient expenses incurred for emergency treatment of injury or acute illness which occurs wholly after the start of travel for up to 30 days of travel to the affected areas in any one policy year.

Waiting Period

Benefits are not paid for sickness during the first 30 days of coverage. Benefits for injuries due to covered accidents occurring wholly after the effective date are covered immediately.

PREMIER INTERNATIONAL PLAN

PACIFIC CROSS

MEDICAL INSURANCE APPLICATION

Name of Policyholder (Family /First/Middle) _____

Address _____ Phone Home _____

_____ Office _____

_____ Mobile _____

E-mail _____ Fax _____

INSURED PERSON'S DETAILS	Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4
Family Name				
First & Middle Name				
Date of Birth (MM/DD/YY)	/ /	/ /	/ /	/ /
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Relationship to Policyholder				
Occupation and Duties				
Height	____Cm / ____Ft ____In	____Cm / ____Ft ____In	____Cm / ____Ft ____In	____Cm / ____Ft ____In
Weight	____Kg / ____Lb	____Kg / ____Lb	____Kg / ____Lb	____Kg / ____Lb
Passport or Government I.D. No.				
Country of Citizenship				
Country of Residence				
PLAN SELECTION				
Premier 250 (US$250,000)	☐	☐	☐	☐
Premier 500 (US$500,000)	☐	☐	☐	☐
ADDITIONAL BENEFITS	☐ Dental	☐ Dental	☐ Dental	☐ Dental
	☐ Travel	☐ Travel	☐ Travel	☐ Travel
	☐ Rental Car Protection	☐ Rental Car Protection	☐ Rental Car Protection	☐ Rental Car Protection
Personal Accident Benefit P.A Sum Insured (in US$10,000's)	☐ _____	☐ _____	☐ _____	☐ _____
Beneficiary Designation				
Relationship to Insured Person				
DISCOUNT OPTIONS				
Treatment Area Limit (TAL)	☐	☐	☐	☐
20% Co-payment	☐	☐	☐	☐
Outpatient Exclusion Option	☐	☐	☐	☐

PAYMENT METHOD

US Dollar (US$) payment can be made by:
1. CHECK payable to **PACIFIC CROSS INSURANCE COMPANY LIMITED**
2. TELEGRAPHIC TRANSFER to the bank account as noted below, or
3. CREDIT CARD using the Payment Authorization Form below.

Telegraphic Transfer Information

Beneficiary Bank: Industrial and Commercial Bank of China (USA) NA
202 Canal Street
New York, NY 10013 USA
ABA No: 026010948
Swift: ICBKUS3N

Beneficiary Account Name: Pacific Cross Insurance Company Limited

Beneficiary Account Number: 62332

Credit Card Payment Authorization Form

Credit Card: ☐ American Express

Name of Cardholder: _____ Credit Card Account No.: _____

Relationship to Policyholder: _____ Expiry Date (Month/Year): _____ / _____

Until further notice (one month advanced written notice is required to terminate this payment instruction), I authorize **PACIFIC CROSS INSURANCE COMPANY LIMITED** to charge the premium including installment payments for this insurance policy to my credit card account.

Signature of Cardholder: _____ Date (MM/DD/YY): _____ /_____ /_____

PAYMENT OPTIONS

☐ **ANNUAL or** ☐ **SEMI-ANNUAL (52% of annual) PREMIUM DUE:**

Preferred Effective Date (MM/DD/YY): _____ /_____ /_____

• MEDICAL QUESTIONS •

Kindly provide information on your medical history. All information provided is kept in the strictest confidentiality. Your complete and accurate responses will assist us to properly underwrite your policy. Each person to be included in the policy is required to complete the below questions. (Parents are required to complete and sign on behalf of children).

	#1		#2		#3		#4	
	YES	NO	YES	NO	YES	NO	YES	NO
1. a) Are you currently covered by any medical insurance policy? (if "Yes", please provide us with a copy of the policy and benefits schedule)	☐	☐	☐	☐	☐	☐	☐	☐
b) Has any medical or life application been declined, rated or restricted? (if "Yes", please explain)	☐	☐	☐	☐	☐	☐	☐	☐
c) Has any medical or life policy been cancelled, withdrawn, rated or restricted (if "Yes", please explain)	☐	☐	☐	☐	☐	☐	☐	☐
2. At any time prior to the application, have you ever had symptoms of or been diagnosed, investigated or treated for any of the following: (underline the specific item and explain in the space provided below)								
a) speech defect, paralysis, hearing loss, physical defect, infirimity, congenital illness, genetic deformity or disease or chronic condition?	☐	☐	☐	☐	☐	☐	☐	☐
b) asthma, respiratory or allergic condition or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐	☐	☐
c) psychiatric or mental disorder, fainting, blackout, mood change, drug/alcohol addiction, seizure or fit?	☐	☐	☐	☐	☐	☐	☐	☐
d) hypertension, high/low blood pressure, chest pain, cholesterol problem, dizziness, heart or circulatory disorder?	☐	☐	☐	☐	☐	☐	☐	☐
e) kidney stone, venereal disease, or disorder of the bladder, prostate, kidney or genito-urinary tract?	☐	☐	☐	☐	☐	☐	☐	☐
f) hepatitis, ulcer, hemorrhoid, colitis or stomach, gall bladder, liver or bowel disorder?	☐	☐	☐	☐	☐	☐	☐	☐
g) sciatica, back pain, joint pain or rheumatic, arthritic, muscle, joint or bone disease or disorder?	☐	☐	☐	☐	☐	☐	☐	☐
h) blood abnormality or blood vessel disorder?	☐	☐	☐	☐	☐	☐	☐	☐
i) HIV, AIDS, AIDS Related Complex, or any indication of blood or immune system disorder?	☐	☐	☐	☐	☐	☐	☐	☐
j) cancer, tumor or cyst?	☐	☐	☐	☐	☐	☐	☐	☐
k) skin disorder?	☐	☐	☐	☐	☐	☐	☐	☐
l) diabetes mellitus, glandular or hormonal disorder?	☐	☐	☐	☐	☐	☐	☐	☐
m) rheumatic fever, gout, malaria or hernia of any kind?	☐	☐	☐	☐	☐	☐	☐	☐
n) gynecological disorder or disease or complication associated with pregnancy?	☐	☐	☐	☐	☐	☐	☐	☐
o) are you pregnant now? (for female only)	☐	☐	☐	☐	☐	☐	☐	☐
p) any other ailment, impairment, or injury?	☐	☐	☐	☐	☐	☐	☐	☐
3. Are you currently undergoing any investigations or taking any medications or receiving any form of treatment recommended or prescribed? (list with dosage)	☐	☐	☐	☐	☐	☐	☐	☐
4. Have you been a patient in a hospital or sanitarium for surgery, observation or treatment in the last 5 years?	☐	☐	☐	☐	☐	☐	☐	☐
5. Have you ever smoked or otherwise used tobacco, including but not limited to cigarettes, cigars, tobacco pipes, nicotine replacement therapy or products such as vaping (e-cigarettes)? (if "Yes", please advise the consumption (pack) and duration of tobacco use)	☐	☐	☐	☐	☐	☐	☐	☐

- If you answered "Yes" to any of the above questions 1 to 5, please give complete details including medical history, diagnosis, nature/date of care and treatment received, date of last consultation and related medical reports, etc. (If the space provided is insufficient, please use a separate sheet for each Insured Person)

_____

_____

_____

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_____

- Kindly provide name and contact details of the personal physician or doctor for each Insured Person.

_____

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_____

_____

_____

_____

_____

_____

Declaration

I hereby apply for a policy to be based on the above statements and declare that, to the best of my knowledge and belief, all answers to the foregoing questions are correctly and accurately recorded, and that they are full, complete and true.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to **PACIFIC CROSS INSURANCE COMPANY LIMITED** any such information. A photostat copy of this authorization shall be as valid as the original.

I further authorize the Company to provide my personal data including but not limited to health and details of the claims incurred to reinsurance companies with whom the Company has or proposes to have dealings or to any agent, contractor or third party service provider who provides services to the Company in connection with the operation of its business.

I hereby declare and agree that the Policyholder shall have the authority to deal with, receive or request for information from the Company concerning the Insured Person(s) in relation to any claims or matters arising from the policy issued pursuant to this application. I further agree that payment of any benefits hereunder to the Policyholder or Insured Person(s) in relation to all claims shall constitute a full discharge on the part of the Company in relation to such claims.

Signature:

Insured Person #1 _____ **Date (MM/DD/YY):** _____ / _____ / _____

Insured Person #2 _____ **Date (MM/DD/YY):** _____ / _____ / _____

Insured Person #3 _____ **Date (MM/DD/YY):** _____ / _____ / _____

Insured Person #4 _____ **Date (MM/DD/YY):** _____ / _____ / _____

Policyholder (if different from the Insured Person) _____ **Date (MM/DD/YY):** _____ / _____ / _____

Broker: _____