



Student Travel Protection Plan Enrollment Form

To calculate your total premium, insert the trip cost, then multiply by the rate factor. Student plan coverage is available up to \$5,000.00.

The current rate factor is: .0360 (Trip of 30 days or less)

Student Plan (Age 26 or younger)

Insured #1

$$\text{\$ } \frac{\quad}{\text{Trip Cost}} \times \frac{\quad}{\text{Rate Factor}} = \text{\$ } \frac{\quad}{\text{Total Premium}}$$

Insured #2

$$\text{\$ } \frac{\quad}{\text{Trip Cost}} \times \frac{\quad}{\text{Rate Factor}} = \text{\$ } \frac{\quad}{\text{Total Premium}}$$

Insured #3

$$\text{\$ } \frac{\quad}{\text{Trip Cost}} \times \frac{\quad}{\text{Rate Factor}} = \text{\$ } \frac{\quad}{\text{Total Premium}}$$

Insured #4

$$\text{\$ } \frac{\quad}{\text{Trip Cost}} \times \frac{\quad}{\text{Rate Factor}} = \text{\$ } \frac{\quad}{\text{Total Premium}}$$

$$\text{\$ } \frac{\quad}{\quad} \\ \text{Total Travel Protection Cost}$$

Note: Trip cost is subject to a \$300.00 minimum.

Please note: This policy contains a preexisting condition exclusion. If you enroll within 14-days of the initial trip deposit the preexisting condition exclusion is waived. For more information regarding this waiver please refer to the back page of our brochure which can be downloaded from this website.

Please mail completed form to:
Assurance Solutions, Inc.
PO. BOX 91004 – Louisville, Kentucky – 40291-0004.
To enroll by phone, or for other information, please call: 1-502-762-9185.
FAX to 502-231-5453



Student Travel Protection Plan Enrollment Form (Continued)

Total Travel Protection Cost: \$ _____ (Total from page 1)

Date of Departure: ____/____/____ Date of Return: ____/____/____

Name of School, Camp, Group, in applicable: _____

Traveler #1 Last Name: _____

Traveler #1 First Name: _____ Birth Year: _____

Traveler #2 Last Name: _____

Traveler #2 First Name: _____ Birth Year: _____

Traveler #3 Last Name: _____

Traveler #3 First Name: _____ Birth Year: _____

Traveler #4 Last Name: _____

Traveler #4 First Name: _____ Birth Year: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: _____ (Please include area code)

E-mail address: _____

Payment Information

Please indicate type of payment:

Check [Payable to ItravelInsured] Mastercard Visa Amex Discover

Card Number: _____ Expiration: _____

Cardholder Name: _____ Signature: _____

Please mail completed form to:

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