



PARTICIPATIVE INTERNATIONAL MEDICAL

INSURANCE Mutualist, affordable, ethical



HEALTH
INSURANCE.TRAVEL

APPLICATION FOR EACH PERSON TO BE COVERED

Expatriation Country:		Gender:	
Nationality:		Passport Number:	
First name:		Middle name (1st):	
Date of birth:		Last name:	
Height (cm):		Weight (kg):	
Phone No:			
E-mail:			

MEDICAL PRE-EXISTING CONDITIONS (IF ANY):

PAST OR PRESENT SICKNESS, PAST SURGERY, MEDICINE TAKEN:

DID YOU HAVE A PREVIOUS COVER (NOT TRAVEL COVER) IF YES, PLEASE SEND US THE INSURANCE CERTIFICATE:

PAYMENT FREQUENCY:							
Monthly:		Quarterly:		Bi-annually:		Yearly:	

PAYMENT CURRENCY:							
USD		EUR		GBP		THB	

MODE OF PAYMENT:	
CREDIT CARD:	BANK TRANSFER:
NAME ON CARD:	
CARD NUMBER:	

VISA CARD		MASTER CARD		AMEX CARD			
EXPIRY DATE:				3 FIG NO. ON REAR			

24 hours Call Centre in Bangkok +66 (0)953697939, +66 (0)27197832-4, E-mail: operations@assistinter.com

UK: 44 Broadway Stratford, London E15 1XH, FRANCE, INDIA, NEVIS, THAILAND, London +66 (0)20260616

Web: www.wrlife.net E-mail: contact@wrlife.net

Insurer licence 51230, Broker licence 16000457



HEALTH INSURANCE PLANS

INTERNATIONAL PLANS:					
SERENITY 100,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
SERENITY 200,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
SERENITY 400,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
SERENITY 600,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
SERENITY 800,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
SERENITY 1,000,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
ELITE 2,000,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	

ECONOMY PLANS:					
ECONOMY PLAN 10,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
ECONOMY PLAN 20,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
ECONOMY PLAN 40,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
ECONOMY PLAN 80,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	

MICRO PLANS:					
MICRO PLAN 1,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
MICRO PLAN 2,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	
MICRO PLAN 3,000 USD		OUT-PATIENT COVER		DENTAL / OPTICAL COVER	

DEDUCTIBLE PER IN-PATIENT CLAIM:									
0 USD		500 USD		1,000 USD		2,000 USD		5,000 USD	

STARTING DATE:		ASSISTANCE EVACUATION REPATRIATION:	
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ADDRESS + CONTACT PERSON:



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 **info@healthinsurance.travel**
 **+1 702 429 1082**

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LIFE & DISABILITY INSURANCE

CAPITAL IN CASE OF DEATH OR TOTAL DISABILITY BY SICKNESS

CAPITAL REQUIRED:	10,000 USD		20,000 USD		30,000 USD	
40,000 USD		50,000 USD		100,000 USD		200,000 USD

CAPITAL IN CASE OF DEATH OR TOTAL DISABILITY BY ACCIDENT

CAPITAL REQUIRED:	10,000 USD		20,000 USD		30,000 USD	
40,000 USD		50,000 USD		100,000 USD		200,000 USD

PERSONAL LIABILITY:

COMMENTS:

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