

OVERSEAS TRAVEL MEDICAL PLAN COST CALCULATION AND RATES

PLAN COST CALCULATION CHART

Enter plan cost for ONE month: \$ _____
 Enter plan cost for ONE day \$ _____
 Only for Payment in Full**** \$ _____
 Multiply by # of Days _____ X
 Subtotal: \$ _____

If other than \$250 Deductible Selected, Multiply subtotal by Factor Indicated Below: (skip if \$250 Deductible selected)
 \$0 x 1.30 = \$ _____
 \$125 X 1.20 = \$ _____
 \$500 X .90 = \$ _____
 \$1,000 X .80 = \$ _____
 \$2,500 X .70 = \$ _____

Optional Sports Rider Multiply X 1.15* = \$ _____
 **Administration Fee
 \$10.00 X _____ months: = \$ _____
 ***Optional: ship policy overnight charge: + \$15.00 = \$ _____
Total Amount Due: = \$ _____

***If you choose Monthly Pay as you go, the \$10.00 Administration fee is charged monthly. If you choose Single pay, the \$10.00 administration fee is charged one time only.*

****The overnight shipping charge overseas is \$25.00.*

*If you are purchasing the Hazardous Sports Rider, please describe the activities for which you are seeking benefits: _____

COMPLETE THE FOLLOWING:

Payment in Full **** Monthly Pay as you go*
 (up to 12 months) (up to 12 months)
 ***Must use daily rate if Payment in Full option selected

COMPLETE PAYMENT MODE:

Check / Money Order Monthly Automatic Bank Draft
 MasterCard Visa Discover

**If You selected Monthly Pay as you go, You must also complete either the Automatic Bank Draft Request or Credit Card Request. Daily must be paid in full*

All payments by check must be made in U.S. dollars.

Make checks payable to and mail to:

**Health Plan Administrators, Inc. (HPA)
 P.O. Box 15250, Rockford, IL 61132-5250**

You can save on postage if you pay by credit card. Simply fax both sides of the completed application to:

1-815-633-0277

METHOD OF PAYMENT REQUESTED

Monthly for the 12 months of plan cost and administration fee
 Only for # _____ days for Payment in Full

CREDIT CARD REQUEST:

Credit Card #: _____
 Expiration Date: _____
 Name as it appears on card: _____
 Billing Address: _____
 Day phone #: _____
 Signature: _____

IF PAYING BY CREDIT CARD:

I authorize Health Plan Administrators, Inc. to debit my VISA, MasterCard or Discover account for the total due amount specified by me. I understand that benefits purchased by credit card are subject to validation and acceptance by the credit card company.

AUTOMATIC BANK DRAFT REQUEST:

By selecting automatic check withdrawal, Your monthly Plan Cost will automatically be withdrawn from Your checking account. Complete the form below.

To: (Bank name): _____
 Address: _____

I request that you pay and charge my account debits drawn from my account by Health Plan Administrators, Inc. to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advanced written notice to me and to Health Plan Administrators, Inc. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my Plan.

 Signature of Plan Payer Date

If payment by Automatic Bank Draft you must attach a voided check with your check for the first month of the Plan Cost.

Cost for the \$250 deductible effective 1-09

US Citizens — Outbound

Available from 5 days to 12 months, Payment in full or Monthly Pay

Limit	\$50,000		\$100,000		\$250,000		\$1,000,000	
	Monthly	Daily	Monthly	Daily	Monthly	Daily	Monthly	Daily
Age Bands								
Child Alone**	\$29	\$1.10	\$34	\$1.23	\$37	\$1.30	\$45	\$1.50
19 - 29	\$30	\$1.00	\$35	\$1.17	\$38	\$1.27	\$47	\$1.57
30 - 39	\$36	\$1.20	\$42	\$1.40	\$52	\$1.73	\$63	\$2.10
40 - 49	\$60	\$2.00	\$68	\$2.27	\$74	\$2.47	\$85	\$2.83
50 - 59	\$103	\$3.43	\$117	\$3.90	\$122	\$4.07	\$133	\$4.43
60 - 64	\$128	\$4.27	\$154	\$5.13	\$164	\$5.47	\$188	\$6.27
65 - 69	\$150	\$5.00	\$166	\$5.53	\$173	\$5.77	\$194	\$6.47
70 - 79	\$223	\$7.43	\$310	\$10.33	N/A	N/A	N/A	N/A
80 +***	\$385	\$12.83	N/A	N/A	N/A	N/A	N/A	N/A
Dep. Child	\$21	\$0.70	\$26	\$0.87	\$30	\$1.00	\$32	\$1.07

Cost for the \$250 deductible effective 1-09

Non-US Citizens (foreign visitors) - Inbound

Available from 5 days to 12 months, Payment in full or Monthly Pay

Limit	\$50,000		\$100,000		\$250,000		\$1,000,000	
	Monthly	Daily	Monthly	Daily	Monthly	Daily	Monthly	Daily
Age Bands								
Child Alone***	\$47	\$1.57	\$55	\$1.83	\$60	\$2.07	\$80	\$2.57
19 - 29	\$48	\$1.60	\$56	\$1.87	\$61	\$2.03	\$83	\$2.77
30 - 39	\$64	\$2.13	\$74	\$2.47	\$83	\$2.77	\$110	\$3.67
40 - 49	\$95	\$3.17	\$107	\$3.57	\$118	\$3.93	\$158	\$5.27
50 - 59	\$145	\$4.83	\$175	\$5.83	\$197	\$6.57	\$246	\$8.20
60 - 64	\$175	\$5.83	\$218	\$7.27	\$247	\$8.23	\$308	\$10.27
65 - 69	\$222	\$7.40	N/A	N/A	N/A	N/A	N/A	N/A
70 - 79	\$280	\$9.33	N/A	N/A	N/A	N/A	N/A	N/A
80 +***	\$484	\$16.13	N/A	N/A	N/A	N/A	N/A	N/A
Dep. Child	\$29	\$0.97	\$33	\$1.10	\$34	\$1.13	\$46	\$1.53

**Outbound coverage not available in all states. See www.hpainsurance.com or call 1-800-277-3323 ext. 3 for details.*

***If more than one child (siblings) for "Child alone" coverage, the oldest child (sibling) should pay the "Child alone" rate and the rest of the siblings the "Dependent child" rates.*

****\$10,000 Maximum Limit for ages 80 and older.*