

MEDICAL INSURANCE APPLICATION FORM

FAX : 416 925 5990 MAIL: Languages Abroad, 386 Ontario, Toronto, ON. Canada M5A 2V7

PERSONAL DETAILS:

PLEASE PRINT CLEARLY

Family name: _____ First name: _____ Sex: M / F _____
Address: _____
City: _____ Province/State: _____
Postal code: _____ Country: _____ Citizenship: _____
Tel.# (Home): _____ Tel. # (Work): _____
Fax #: _____ E-mail address: _____
Date of birth: D ____ /M ____ /Y ____ Age: _____ Smoker/non smoker: _____
Contact Person in case of an emergency: (Name / Tel. #): _____
How did you hear of Languages Abroad?: _____

INSURANCE COVERAGE INFORMATION:

Dates: From D ____ /M ____ /Y ____ To D ____ /M ____ /Y ____ Weeks _____
Destination: _____
Other information: _____

FEES :

All prices in US Dollars

Medical / Travel insurance coverage.

(Additional cost, \$30.00 per week) \$ 30.00 x _____ Weeks \$ _____ Total Price

APPLICANT'S SIGNATURE _____ DATE D ____ /M ____ /Y ____

By signing this form you agree and understand the general terms and conditions of Languages Abroad and agree to them.

Please complete and submit the enrollment form either by fax to (416) 925 5990 or please mail it to the address, which is at the top of this form.

Please note full payment must be received with all applications, if registering by mail, please enclose a cheque or you may also pay by credit card.

If paying by credit card, please print off the credit card approval form (this can be found on our website) and fax this along with your application to (416) 925 5990.

Should you have any further questions please call us at 1 800 219 9924 or (416) 925 2112