



CAREMED APPLICATION

Name _____

Date of Birth (month/day/year) ____/____/____ Country of Citizenship _____

Please enroll me in the following health plan:

____ Option A (HAZ1LSC) \$42/month
Health/illness and medical treatment in case of an accident; luggage.
Medical coverage up to \$250,000; \$100 deductible.

____ Option B (HAITL3Z1LSC) \$52.40/month
Health/illness and medical treatment in case of an accident; indemnity; travel assistance;
luggage; third party liability. Medical coverage up to \$250,000; \$100 deductible.

____ Option C (HAZ1LGA) \$74/month
Health/illness and medical treatment in case of an accident; luggage.
Unlimited medical coverage; no deductible.

____ Option D (HAITL3Z1LGA) \$86.20/month
Health/illness and medical treatment in case of an accident; indemnity; travel assistance;
luggage; third party liability. Unlimited medical coverage; no deductible.

Start date of coverage (month/day/year) ____/____/____ End date of coverage ____/____/____

Total number of months ____ X premium per month \$ ____ = Total Due \$ _____

Payment must be in U.S. dollars. Please make checks payable to Dance New Amsterdam.

Payment: Money Order ____ Check ____ Credit Card (Master Card ____ Visa ____)
Credit Card # _____ Expiration Date ____/____

I hereby apply for insurance under the CareMed International Travel insurance policy issued to CareMed GmbH, Bonn, Germany underwritten by ACE European Group Ltd. I understand the terms and conditions of the insurance plan are provided in the CareMed International Travel Insurance booklet. I do not hold Dance New Amsterdam responsible for any decisions of the insurer, included but not limited to rejection of any claim or extension.

Signature _____ Student Signature _____
On behalf of Dance New Amsterdam

Date ____/____/____ Date ____/____/____