



**SUPPLEMENTAL APPLICATION FORM FOR OPTIONAL HIGHER LIMITS — AD&D**

This Application is required for Gateway Global 1 – Enhanced Plan Option 1 — AD&D Coverage above \$500,000. All items must be completed and submitted for review. Coverage is not guaranteed. This form will be returned to you with notification of acceptance and the additional premium required or with explanation and notice of non-acceptance at the address or fax number you provide below.

**IMPORTANT NOTE ABOUT APPLICATION APPROVAL PROCESS**

In most cases, responses will be sent within 5 business days from the time we receive your supplemental Application Form. In the event your request for increased AD&D limits cannot be reviewed and approved prior to your Plan’s Effective Date, coverage will be issued for \$500,000.

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Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

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Increased limits apply to Primary Insured only and are not available to covered dependents. Refer to the Global 1 Rate Chart on the Gateway Global Application Form for premium rates.

Select the type of travel which best fits the primary purpose for this coverage:       Business       Leisure Travel       Other

Indicate the percentage of travel anticipated during the annual term:                      \_\_\_\_\_%                      \_\_\_\_\_%                      \_\_\_\_\_%

Your occupation: \_\_\_\_\_  
*(provide a brief description of occupational activities while traveling abroad)*

Answer the following question regarding your medical history: Are you in good health and free from physical impairment?     Yes     No

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I hereby apply to the Insurance Company of the State of Pennsylvania, a member company of American International Companies for insurance to be issued solely and entirely in reliance upon the written answers to the foregoing questions which I represent to be true, full and complete to the best of my knowledge and information.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

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Fax or mail your completed and signed Application to the Gateway Plan Administrator prior to your Effective Date of insurance.

**Fax: 202-367-5076**  
**Gateway Plan Administrator**  
12421 Meredith Drive  
Mail Stop GT10  
Urbandale, IA 50323

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**FOR ADMINISTRATOR USE ONLY**

Applicant Name: \_\_\_\_\_  
Option 1: AD&D Limits Approved:                      \$ \_\_\_\_\_

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