PARTNERS OF THE AMERICAS

Accident & Health Insurance Enrollment Form

This enrollment form is for volunteers who are traveling *__on or after 08/01/06__* and *__not__* paid for by Partners of the Americas

PLEASE PRINT CLEARLY

Last name: ________________________________ First name: ________________________ M.I. ________

Mailing address: ____

____

City: __________________________________ State: ______________ ZIP: ______________

Home phone #: ______________________________ E-mail: ____________________________

Date of birth (MM/DD/YY): ________________ Social Security #: ________________________ M ☐ F ☐

Home country: ____________________________________

Host country: ____________________________________

Effective date*: ____________________________ (MM/DD/YY)

Expiration date*: ____________________________ (MM/DD/YY)

***Remember to include departure date and return date when requesting coverage.**

Premium rate: $12.65 per person per week* Total premium: $_________________

***minimum 2 week of coverage**

Please enclose check or money order payable to ABCO 100 and mail to:

ABCO 100
7-C TERRACE WAY
GREENSBORO, NC 27403