AUTHORIZATION TO CHANGE/REFUND OR TRANSFER TRAVEL INSURANCE POLICY

NOTE: SINCE TRAVEL INSURANCE IS A LEGAL CONTRACT BETWEEN THE INSURANCE COMPANY AND THE POLICY OWNER, ALL CHANGES TO A POLICY OR A REQUEST FOR A REFUND OR CANCELLATION **MUST CONTAIN THE SIGNATURE OF THE POLICY OWNER** AND THE DATE AND REASON FOR THE REQUEST. NO CHANGES, REFUNDS OR CANCELLATIONS WILL BE GRANTED WITHOUT THIS WRITTEN REQUEST.

REFUND POLICY: A POLICY OWNER HAS TEN (10) DAYS FROM THE DATE OF RECEIPT OF THE DESCRIPTION OF SERVICES AND BENEFITS BOOKLET TO REQUEST A FULL REFUND. NO REFUNDS WILL BE GRANTED FOR ANY SINGLE TRIP POLICY IF THERE HAS BEEN A CLAIM FILED, IF THE POLICYOWNER IS “IN PENALTY” WITH THE TRAVEL SUPPLIER OR IF THE ORIGINAL DEPARTURE DATE HAS OCCURRED.

IF CANCELLATION IS DESIRED, WE WILL BE HAPPY TO TRANSFER YOUR INSURANCE COVERAGE TO A NEW BOOKING PROVIDED IT IS REBOOKED WITH YOUR TRAVEL AGENT WITHIN THIRTY (30) DAYS OF THE ORIGINAL CANCELLATION REQUEST DATE. YOU WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM IF THE TRIP COSTS MORE OR WE WILL REFUND YOU THE DIFFERENCE IN PREMIUM IF THE TRIP COST IS LOWER THAN THE ORIGINAL AMOUNT. WE CANNOT TRANSFER OR REFUND IF THE ORIGINAL TRAVEL DEPARTURE DATE HAS ALREADY OCCURRED. THE POLICY OWNER IS THE PERSON WHO PAID THE PREMIUM.

Policy Owner’s Full Name:

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Street Address: ____

City, State, Zip Code: ____

Invoice Number: ____

Travel Agency Name: ____

Date of Change/Refund/Cancellation Request: ____________________________

Reason for Change/Refund/Cancellation Request: __________________________

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New Travel Dates: Depart:___________________ **Return**__________________

New Cost of Trip: $_________________

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Signature of Policy Owner **Date of Signature**

Fax or Mail Changes to: GMCG, Inc., P.O. Box 9576, Coral Springs, FL 33075-9576
Fax: (954) 227-8884