

INSURANCE INVOICE

Family Vacation Protection

INVOICE #

DATE

INSURER INFORMATION

[Agency Name]

[Street Address]

[City, State, Zip]

[License Number]

POLICY HOLDER

[Primary Insured Name]

[Street Address]

[City, State, Zip]

[Phone Number]

POLICY DETAILS

Plan: _____

Policy ID: _____

COVERAGE PERIOD

Departure: _____

Return: _____

Description of Coverage	Insured Members	Premium Amount
Travel Medical & Emergency Evacuation	[Family Count]	\$0.00
Trip Cancellation & Interruption	[All]	\$0.00
Baggage & Personal Effects Loss	[All]	\$0.00

Description of Coverage	Insured Members	Premium Amount
Optional "Cancel For Any Reason" Upgrade	-	\$0.00

Subtotal: \$0.00
Taxes/Fees: \$0.00
Total Due: \$0.00

PAYMENT TERMS

Premium must be paid in full prior to the departure date to validate coverage. Please include Policy ID with your payment.

Thank you for choosing us to protect your family's journey.