

# MEDICAL TRAVEL INSURANCE

[Agency/Company Name]

[Address Line 1]

[Contact Email/Phone]

INVOICE NUMBER

[INV-0000]

DATE OF ISSUE

[DD/MM/YYYY]

POLICY HOLDER (INSURED)

[Full Name]

[Passport Number]

[Residential Address]

[Country of Origin]

COVERAGE DETAILS

Policy Type: [Single Trip/Annual]

Destination: [Country/Region]

Start Date: [DD/MM/YYYY]

End Date: [DD/MM/YYYY]

Description of Coverage / Plan	Units/Days	Rate	Amount
[Insurance Plan Name - e.g., Platinum Global Health]	[00]	[0.00]	[0.00]
[Add-on: Extreme Sports/Pre-existing Condition Cover]	[00]	[0.00]	[0.00]

Description of Coverage / Plan	Units/Days	Rate	Amount
[Administrative/Policy Fees]	1	[0.00]	[0.00]

Subtotal: [Currency] [0.00]

Tax/VAT: [0.00]

Total Payable: [Currency] [0.00]

PAYMENT STATUS

[Paid / Pending / Partial]

**Note:** This insurance coverage is subject to the terms and conditions outlined in the Policy Wording document. Medical emergency assistance is available 24/7 at [Emergency Number].

Payment Instructions: [SWIFT/IBAN/Wire Transfer Details]