

SeniorTravel Shield

123 Assurance Way
Medical District, NY 10001

INVOICE

Date: _____
Invoice #: _____

Policy Holder:

Name: _____
Address: _____
DOB: _____

Policy Summary:

Policy ID: _____
Effective Date: _____
Expiration Date: _____

Coverage Description	Benefit Limit	Premium Amount
Emergency Medical & Evacuation (Age 65+)	\$ _____	\$ _____
Trip Cancellation & Interruption	\$ _____	\$ _____
Pre-existing Condition Waiver Fee	Included	\$ _____
Baggage & Personal Effects	\$ _____	\$ _____

Subtotal: \$ _____

Tax/Fees: \$ _____

Total Due: \$ _____

Payment Status: Pending Paid

Please make checks payable to SeniorTravel Shield. For claims assistance, call 1-800-XXX-XXXX.

This document serves as an invoice for insurance services rendered.