



**Able Trek  
(TOURS)**  
 P.O. Box 384 Reedsburg, WI 53959  
 608-524-3021 1-800-205-6713  
 Fax 608-524-8302 www.abletrektours.com

2024 OFFICE USE	
<input type="checkbox"/> SEIZURES	<input type="checkbox"/> LIFT <input type="checkbox"/> T/D
<input type="checkbox"/> DIABETIC <input type="checkbox"/> Insulin	<input type="checkbox"/> ADA Accommodations
<input type="checkbox"/> SX Inappropriate	<input type="checkbox"/> (1:1) <input type="checkbox"/> (1:2) <input type="checkbox"/> OWN
<input type="checkbox"/> BLIND <input type="checkbox"/> SMOKER	<input type="checkbox"/> CPAP <input type="checkbox"/> INCONTINENT
<input type="checkbox"/> ALLERGY _____	

Date: \_\_\_\_\_

# 2024 TRAVELER APPLICATION

Please complete this application in full. Attach additional pages and/or any behavioral programs.  
 All information will be held in confidence and is required to ensure a safe, enjoyable, and positive travel experience. **Print or type clearly.**

**Traveler's FULL LEGAL NAME:** \_\_\_\_\_  
 (Last) (First) (Middle) (Common First Name)

Indicate the Traveler's **FULL LEGAL NAME EXACTLY AS IT APPEARS ON THEIR I.D. CARD OR PASSPORT.** This is **CRITICAL** for flight, rail and cruise trips. Not providing the EXACT FULL LEGAL NAME will result in security issues at airports, etc., and financial penalties for name change fees. **Attach a copy of the Traveler's photo ID or passport (whichever is applicable) if they are attending a flight, cruise or international vacation.**

Address: \_\_\_\_\_  
 (Street and/or Box #) (City) (State) (Zip code)

Traveler's Phone: Home (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_ Email \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ Male \_\_\_\_ Female

**An AMBULATION category MUST be indicated or the application is incomplete and will not be accepted.**

\_\_\_\_ **AMBULATORY** (Able to walk a distance of 1 to 2 blocks at a time, can independently climb 10 stairs.)

\_\_\_\_ **PARTIALLY AMBULATORY** Uses a walker or cane? Yes / No Can climb 5 steps? Yes / No  
 Unsteady, easily fatigued, lacks strength or needs assistance walking? Yes / No  
 Able to transfer independently (from wheelchair, toilet, seat, etc.) without assistance? Yes / No

Briefly explain: \_\_\_\_\_  
 \_\_\_\_ **NON-AMBULATORY** Uses a wheelchair? Yes / No (Describe in detail on page 2 of Ambulation section)

**Hotel Accommodations (CHOOSE)** \_\_\_\_ Double (2 guests/2 beds) \_\_\_\_ Single (1 guest/1 bed) \_\_\_\_ ADA (Handicap Accessible w/1 bed)

**Traveler's Parent or Guardian:** (name) \_\_\_\_\_

Address: \_\_\_\_\_  
 (Street and/or Box #) (City and State) (Zip code)

Phone: Home (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_

Email address (print clearly): \_\_\_\_\_

**Traveler's Doctor:** (name) \_\_\_\_\_

Doctor's Phone: (days) (\_\_\_\_)\_\_\_\_-\_\_\_\_ (evenings) (\_\_\_\_)\_\_\_\_-\_\_\_\_

In the event of an **emergency contact** (Indicate two people):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: Home (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: Home (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_

**To whom should ALL travel correspondence be sent? (Traveler Forms, Final Itinerary, Packing List, Reminders, etc)**

Agency Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_  
 (Mailing Address -Street and/or Box #) (City and State) (Zip code)

Phone: Days (\_\_\_\_)\_\_\_\_-\_\_\_\_ Evening (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_

Email address (print clearly): \_\_\_\_\_

Please include an email address. Much of our tour correspondence and reminders are sent via email.

**Who will be paying for the trip? (Traveler, guardian/parent, agency, etc.)** \_\_\_\_\_

\* The Traveler's name and SPECIFIC trip title MUST be indicated with ALL payments.

**ABILITIES AND DISABILITIES: (Check all that apply)**  Not Disabled  Learning Disabled  
 Cognitively / Developmentally Disabled  
 Mild  Moderate  Severe  Profound  
 Physically Disabled  
 Blind  Hearing Impaired  Non-Verbal  Limited Mobility

**AMBULATION**

*Travelers who require mobility related care and/or need any assistance transferring are REQUIRED to provide their own caregiver who is familiar with their cares and needs. Travelers who require assistance transferring (toileting, dressing, bedtime, etc.) are welcome to travel but ONLY accompanied by their own personal caregiver. Able Trek staff are not permitted to lift travelers or assist with transferring. Providing inaccurate or incomplete information about a traveler's mobility needs will result in the Traveler not being allowed to travel.*

**DOES THE TRAVELER HAVE LIMITED MOBILITY?**  No  YES **If YES, complete section below.**

Manual Wheelchair  Electric Wheelchair  Uses Walker  Tires Easily

Is the Traveler able to independently navigate 5 steps to board the motorcoach?  Yes  No  
 Do the Traveler & their wheelchair require a tie-down location (no transfer) in the bus?  Yes  No  
 Can the Traveler independently transfer from their w-chair into & ride in bus/vehicle seat?  Yes  No  
 Can the Traveler independently transfer (on/off toilet, in/out of bed)?  Yes  No  
 ★ Does the Traveler require an ADA accessible room w/roll-in shower stall at the hotels?  Yes  No

★ Travelers who require ADA fully accessible lodging accommodations (roll-in showers, wide door entrances, grab bars in bathroom, etc. will be required to pay the "Single/ADA" rate because these rooms have only one bed.

**BASIC INFORMATION (Please check any of the following that apply):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Reads                          | <input type="checkbox"/> Wanders (Describe below)      | <input type="checkbox"/> Heart Condition                   |
| <input type="checkbox"/> Writes                         | <input type="checkbox"/> Blood Disorder                | <input type="checkbox"/> Pacemaker/defibrillator           |
| <input type="checkbox"/> Poor Coordination /Balance     | <input type="checkbox"/> Mentally Ill                  | <input type="checkbox"/> VAD (Ventricular Assist Device)   |
| <input type="checkbox"/> Trips/Falls Easily             | <input type="checkbox"/> Psychological Impairment      | <input type="checkbox"/> Speech Impairment                 |
| <input type="checkbox"/> Episodes of Dizziness          | <input type="checkbox"/> Mood/personality disorder     | <input type="checkbox"/> Non-verbal                        |
| <input type="checkbox"/> Uses Adaptive/Assistive Equip. | <input type="checkbox"/> Sensory Issues                | <input type="checkbox"/> Uses ASL (American Sign Language) |
| <input type="checkbox"/> Cerebral Palsy                 | <input type="checkbox"/> Autism                        | <input type="checkbox"/> Irregular Sleeping                |
| <input type="checkbox"/> Muscular Dystrophy             | <input type="checkbox"/> Obsessive/Compulsive Disorder | <input type="checkbox"/> Snores Loudly                     |
| <input type="checkbox"/> Spina Bifida                   | <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Smokes (Amount? _____ )           |
| <input type="checkbox"/> Multiple Sclerosis             | <input type="checkbox"/> Visually Impaired             | <input type="checkbox"/> Fear of Heights                   |
| <input type="checkbox"/> Stroke (any deficit describe)  | <input type="checkbox"/> Wears Glasses                 | <input type="checkbox"/> Fear of Water                     |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Wears Dentures                | <input type="checkbox"/> Swimmer                           |
| <input type="checkbox"/> Terminal Illness               | <input type="checkbox"/> Wears Hearing Aids            | <input type="checkbox"/> VNS (Vagus Nerve Stimulation)     |

Describe, **in detail**, any item checked above that will help our staff provide quality care: \_\_\_\_\_

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**Can the Traveler take\* :** Aspirin – Yes / No      Tylenol – Yes / No      Ibuprofen – Yes / No  
 Loperamide – Yes / No      Kaopectate – Yes / No      Pepto Bismal – Yes / No      Dramamine – Yes / No  
 Antacid – Yes / No      Decongestant – Yes / No      Cough Syrup – Yes / No

\* If the OTC medications allowed on Application differ from those allowed on the Medical Evaluation, the Medical Evaluation will take priority.

**DETAILED INFORMATION:** Provide as much **SPECIFIC** information and **DETAILS** as you can. This helps our staff to provide the best possible care for the Traveler. Attach additional pages if necessary.

**TOILETING:**  Independent      Incontinent - Yes / No      Catheterization - Yes / No  
 Needs assistance      If yes:  Urine  Stool      If yes:  Independent  
 Wears Depends       Rare  Frequent       Needs assistance

Explain: \_\_\_\_\_

**DRESSING:** \_\_\_ Independent \_\_\_ Partial Assistance (describe) \_\_\_ Total (physical) Assistance (describe in detail)

**SHOWERING:** \_\_\_ Independent \_\_\_ Requires physical assistance \_\_\_ Set water temp \_\_\_ Assistance shampoo  
\_\_\_ Requires a roll/walk in shower

**GROOMING:** \_\_\_ Independent \_\_\_ Teeth Brushing-Set up Assist \_\_\_ Assist w/shaving \_\_\_ Assist w/hair care

**MEAL TIME:** \_\_\_ Independent \_\_\_ Cut/chop food \_\_\_ Mechanical soft \_\_\_ Pureed \_\_\_ Staff Must Feed  
\_\_\_ Assistance ordering \_\_\_ Assistance paying \_\_\_ Food Allergies \_\_\_ Special Diet

**DIABETIC?** \_\_\_ NO \_\_\_ YES If YES, complete the rest of this section. \_\_\_ Type 1 \_\_\_ Type 2  
Does the Traveler test blood glucose levels? \_\_\_ NO \_\_\_ YES If YES, do they test independently? \_\_\_ NO \_\_\_ YES  
Requires insulin injections? \_\_\_ NO \_\_\_ YES If YES, do they self-inject or need assistance? \_\_\_ SELF \_\_\_ ASSIST  
Describe in **DETAIL** diabetic care – typical levels, are levels normally stable or unstable, dietary details, etc.

**MONEY MANAGEMENT:** \_\_\_ Independent (Traveler will handle, count and budget own money on the trip)  
\_\_\_ Semi-independent (can carry a small amount of money but staff needs to hold the majority of their money)  
\_\_\_ Complete Assistance (staff need to hold onto all money and assist with all purchases)

**TIME MANAGEMENT:**  
Getting “ready” in the morning: \_\_\_ 30 minutes or less \_\_\_ 30 minutes to 1 hour \_\_\_ Over 1 hour  
Eating/meal time: \_\_\_ 30 minutes or less \_\_\_ 30 minutes to 1 hour \_\_\_ Over 1 hour

**EPILEPSY/SEIZURE DISORDER?** \_\_\_ NO \_\_\_ YES If YES, complete the rest of this section.  
TYPE: \_\_\_ Atonic (drop seizures) \_\_\_ Petit Mal (Absence seizures) \_\_\_ Tonic Clonic (Grand Mal) \_\_\_ Partial  
Are the Traveler’s seizures well controlled? \_\_\_ NO \_\_\_ YES Describe in **DETAIL** (frequency, length, recovery time, care after seizure, when EMT or hospitalization should be sought, etc.).

**MEDICATION MANAGEMENT:** Will the Traveler be taking medication on the trip? \_\_\_ NO \_\_\_ YES  
Is the Traveler completely self-medicating (be aware routines can be distorted on trips)? \_\_\_ NO \_\_\_ YES

Reason(s) for medication(s):

**ANY ALLERGIES TO MEDICATIONS? :**

**EVENING/SLEEPING ROUTINE:** Normal time to bed: \_\_\_\_\_ PM Normal wake-up time: \_\_\_\_\_ AM  
**CPAP?** \_\_\_ YES \_\_\_ NO Does the Traveler normally sleep through the night? \_\_\_ YES \_\_\_ NO  
If NO, describe below. Include any details about sleeping patterns (snores loudly, goes to sleep with TV on, talks in sleep, incontinence at night, etc).

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**BEHAVIORAL and INTERACTION INFORMATION/CONCERNS:**

Please indicate and describe in detail any behavioral concerns that apply to the Traveler.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Injurious to self  | <input type="checkbox"/> Physically aggressive toward others   | <input type="checkbox"/> Destructive to property |
| <input type="checkbox"/> History of stealing  | <input type="checkbox"/> Does not follow verbal directions     | <input type="checkbox"/> Inappropriate touch     |
| <input type="checkbox"/> Verbally aggressive  | <input type="checkbox"/> Interacts inappropriately with others | <input type="checkbox"/> Fabricates stories      |
| <input type="checkbox"/> Does not function well in organized activities unless supervised 1:1                 |  | <input type="checkbox"/> Sexually inappropriate  |
| <input type="checkbox"/> Does not accept staff assistance, reminders, support, etc. in an appropriate manner. |  |  |

Please describe any behavioral concerns and how they are best handled. \_\_\_\_\_

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Has the Traveler been with Able Trek Tours on a previous vacation? (Circle one) Yes / No

Has the Traveler ever been denied access to other vacation, camp or leisure providers? (Circle one) Yes / No

Traveler's Likes: \_\_\_\_\_

Traveler's Dislikes: \_\_\_\_\_

Traveler's Fears: \_\_\_\_\_

Traveler's Special Skills: \_\_\_\_\_

What expectations does the Traveler, parents (guardian) and/or caregivers have for this vacation?

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**Trip staff to Traveler ratio is 1:3 or 1:4.** Care/supervision on vacations tends to be more intensive and demanding than in the home setting. A traveler that is unable to independently transfer from their wheelchair is required to provide their own support staff on trip(s). **Will the Traveler function well with this level of supervision?** If no, explain.

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*\* Staff to Traveler ratio of 1:1 is available in many circumstances. Travelers can bring their own support staff or staff can be supplied by Able Trek Tours. The typical cost for 1:1 staffing, for both the Traveler and staff, is 150% (1 1/2 times) the published DOUBLE rate. You MUST inform Able Trek Tours well in advance of the trip if you feel the Traveler would function better with a 1:1. Able Trek may also determine and require that a Traveler requires 1:1 staffing to attend. Most Travelers who use a wheelchair for mobility and/or require transfer assistance will be required to supply their own 1:1 support staff.*

**INSURANCE COVERAGE:** Insurance for accidents or illnesses while participating in Able Trek Tours is the responsibility of the Traveler and/or their family or guardian. Please list the Traveler's health/accident; medical/hospital insurance coverage. Travel cancellation insurance including some medical coverage is available – contact Able Trek Tours for info.

CARRIER: \_\_\_\_\_ POLICY/GROUP #: \_\_\_\_\_

MEDICAL ASSISTANCE #: \_\_\_\_\_

OTHER: \_\_\_\_\_

## ABLE TREK TOURS CONSENT FORM

Traveler's Name: \_\_\_\_\_

Trip Title: \_\_\_\_\_ Trip Date: \_\_\_\_\_

Trip Title: \_\_\_\_\_ Trip Date: \_\_\_\_\_

Trip Title: \_\_\_\_\_ Trip Date: \_\_\_\_\_

Trip Title: \_\_\_\_\_ Trip Date: \_\_\_\_\_

Is the Traveler his or her own legal guardian? (Circle one) Yes / No

**Instructions:** Check each paragraph after reading to indicate that you understand and agree with it.

- \_\_\_\_\_ 1. I hereby attest all information within this application to be true and accurate to the best of my knowledge.
- \_\_\_\_\_ 2. I understand failure to provide accurate information my result in immediate dismissal from any Able Trek Tours program.
- \_\_\_\_\_ 3. I hereby give permission for Able Trek Tours to use photographs or video footage taken of the Traveler in publications or presentations in promotion of Able Trek Tours.
- \_\_\_\_\_ 4. I agree not to send any Traveler on any Able Trek Tour if they have been exposed to a contagious disease within four weeks of the trip start date.
- \_\_\_\_\_ 5. I am aware of, understand and agree to the cancellation timelines and financial penalties as described on pages 25-26 of the Able Trek Tours Vacation Packages booklet.

### TRAVELER'S CONSENT:

I agree to participate in the above stated Able Trek Tour(s). I have paid careful attention to all the above statements and understand them.

Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### LEGAL GUARDIAN'S CONSENT (if Traveler is not own legal guardian):

I am the parent and/or legal guardian of the above-mentioned Traveler, and I give my permission for (name of Traveler) \_\_\_\_\_ to participate in the above stated Able Trek Tour(s). I have carefully read all the above statements, understand them, and agree to abide by them.

Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_ Email address: \_\_\_\_\_

Phone: (days) (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ (evenings) (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ (cell) (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

**If participant will be taking a vacation that includes flight, cruising, rail or international travel; please attach a legible copy of the Traveler's state issued photo I.D., driver's license or passport book (whichever is applicable).**



# Able Trek TOURS POLICIES & INFORMATION

## SMOKING POLICY

Participants may smoke only on planned rest stops and during designated free times in allowable areas. There is absolutely no smoking in vehicles or hotel rooms. Most attractions we visit have a no smoking policy. Travelers found smoking in hotel rooms will be responsible for hotel fees.

## DRUGS AND ALCOHOL

Possession or use of illegal drugs or non-prescribed medications and consumption of alcoholic beverages is strictly prohibited by both Travelers and support staff during any trip. This uniform policy is required for the safety and wellbeing of all participants.

## ILLNESS / INJURY

If a participant becomes ill or injured and cannot continue to travel with the group, and requires transportation home will be responsible for such transportation costs. Able Trek offers travel insurance at an additional fee. See bottom of page or contact Able Trek for more information.

## PROPERTY DAMAGE OR DESTRUCTION

Participants who, intentionally or unintentionally damage or destroy property not belonging to themselves, are financially responsible for repair or replacement of damaged or destroyed property. Able Trek Tours, its staff and volunteers accept no financial responsibility for damaged or destroyed property.

## MEDICATION DISPENSING

All non-self-medicating participant's medications and prescriptions must be individually pre-packaged according to the time and date of each dispensing. The guardian/parents/care staff/are responsible for making sure this is completed accurately. **Medications should not be packed in a Traveler's suitcase.** An extra day's supply of medications should be sent in case of emergency or trip delay. All medications will be surrendered to the Tour Director or person responsible for dispensing the medications at the time of check-in. Travelers who normally self-medicate can continue this practice on trips and package their medications in the way they are familiar with. Only send medications needed for trip length plus one day.

## APPLICATION PROCESS

All information provided to Able Trek Tours must be complete and accurate to the best knowledge of the person completing the Traveler's Application. **Failure to provide accurate or complete information may result in immediate dismissal from any travel program.** Parent, guardian, care staff, and/or person completing the Traveler Application must provide immediate transportation home for the participant from any location should inaccurate and/or false information result in unknown safety (whether caused by behavioral, medical or ambulatory factors) for the Traveler, staff persons, other participants or persons in the community unless other arrangements are made with Able Trek Tours. No refund is available to the participant or their agent if the above is the case.

If known health and/or known behavioral concerns result in safety concerns for the participant, staff, other Travelers or persons in the community, the parent, guardian, care staff and/or person completing the application in cooperation with Able Trek Tours will provide/arrange to provide transportation home for the participant. In this case partial refunds or credits to account may be available.

Consent and waiver signatures must be those of the legal guardian. The Traveler Application will not be processed with unauthorized signatures. Participants should sign where indicated whether they are self-guardians or not.

**Requesting trip information does not sign-up or guarantee a place for that tour.** A booking is secured when the deposit for multi-day trips or payment in full for one-day trips is received. The Medical Evaluation (Physical form) must be received by Able Trek Tours no later than 45 days prior to each trip. It must be completed and signed by a physician, NP or PA. The Medical Evaluation form must be completed based on a physical exam completed within 12 months of the trip.

## CONFIRMATION/CANCELLED TRIPS

Confirmation of booking along with needed paperwork will be sent within 14 days of receiving payment. Able Trek reserves the rights to cancel any session (trip) due to insufficient registration. In the event of cancellation; Travelers will be offered first choice in registering for other open trips, or their fees will be refunded in full.

## TRIP FEE POLICIES

**Requesting trip information does not sign-up or guarantee a place for that tour.** A booking is secured when the deposit for multi-day trips or payment in full for one-day trips is received. *One-day trips require payment in full within three weeks of requesting trip information. Multi-day trips require a deposit within two weeks of requesting information with payment in full no later than 60 days prior for motorcoach tours and a minimum 90 to 120 days prior for international, cruises and trips that include a flight.* Specific payment information is included on each trip's itinerary. Payment by check or money order is preferred. Card payments incur a \$10 service fee plus a 3% processing fee. Booking confirmation will be sent with needed paperwork once payment has been received by Able Trek.

## FUEL SURCHARGE & TRIP ALTERATIONS

In the event of rising fuel costs, and/or airfares, Able Trek Tours, Inc. reserves the right to add a surcharge, not to exceed 10% of the trips cost. Because of ever-changing attractions, shows, schedules, etc., Able Trek Tours reserves the right to make substitutions and changes in the trips when necessary.

## REFUNDS AND CANCELLATIONS

Please note: Some vacations may have more restrictive cancellation policies and penalties. If this is the case it will be indicated on the trip itinerary. **Travelers who are "no shows" on the day of departure receive no refund whatsoever. Travelers who are "late" on the day of departure are considered no shows.** Travel Insurance is available for all trips; see below for information on how to request a quote.

### ➤ Motorcoach/Land Tours

All monies paid will be refunded if notice of cancellation is received by Able Trek Tours 45 days or more prior to each trip start date for motorcoach tours.

### ➤ Air, Rail, Cruise, and International Tours

Please see each trip itinerary for specific cancellation policies. In general, all monies paid will be refunded if notice of cancellation is received by Able Trek Tours 90 to 120 days or more prior to each trip start date.

## TRAVELER IDENTIFICATION REQUIREMENTS

All Travelers should have a CURRENT/VALID (check expiration date) state issued photo I.D. for every trip. Additional identification will be REQUIRED for trips that include air, rail, cruise or international travel. Specific I.D. requirements will be sent with each trip itinerary. **Travelers who are refused boarding on any vacation due to lack of proper and current identification will not receive a refund whatsoever. Any travel outside the United States, even Canada and Mexico, will require a Passport BOOK – NO EXCEPTIONS!! "REAL" ID's will be required for all domestic air travel after 5/6/25.**

## TRAVEL INSURANCE

Travel insurance can be purchased to protect your if you are forced to cancel for a variety of reasons. It also includes coverage for some accidents and illnesses. To receive a quote, purchase or receive detailed information about **Travel and Cancellation Protection** coverage you may visit our website for a link to Travel Insured. <http://www.travelinsured.com/agency?agency=49342> or call Travel Insured at 855-752-8303.