Global Explorer Insurance - Individual Application

1. Complete all sections and sign the Application.
2. If paying by check or money order, please make payable to IMG and enclose in envelope with signed Application.
3. Mail, fax or email completed Application to:

International Medical Group, Inc.
P.O. Box 88509
Indianapolis, Indiana
46208-0509 USA
Fax: 1.317.655.4505
Email: insurance@imglobal.com

Please Print: ☐ Male ☐ Female
Primary Applicant's Name: Mr. / Mrs. / Ms. **Last:** _____ **First:** _____ **Middle:** _____
Mailing Address: _____
Country of Citizenship: _____ **Country of Residence:** _____
Destination Country: _____ **Phone:** _____

Send Confirmation of Coverage and communications to the following Email:
_____

If mailing address above is in Florida, is the applicant currently located in Florida? ☐ Yes ☐ No
(Determines applicable surplus lines tax and will not affect coverage.)

Requested effective date of coverage: _____ Requested expiration date: _____
Date of Departure from home country: _____ Date of return to home country: _____
Date of arrival in the U.S. (Required if your destination country is the U.S. or U.S. Territory): _____

Government Issued ID Number: _____

Beneficiary (for individuals selecting the Platinum plan):
Primary: _____ Contingent: _____

1. Select the plan option ☐ **Standard** ☐ **Platinum**

2. Names of individuals applying for coverage:

Insured Name(s)	Date of Birth	Monthly Premium Rate		# of Months		Daily Premium Rate		# of Days	
Primary Applicant			X		=		X		=
Spouse			X		=		X		=
Child			X		=		X		=
Child			X		=		X		=

Total Monthly premium = _____ **Total Daily premium** = _____

Subtotal (Monthly + Daily premium) = _____
Adventure Sports Rider (multiply by 1.20 if requested) x _____
Express Mail (add $20 if requested) + _____
TOTAL AMOUNT DUE = _____

IMG Producer Use Only

Producer #_____
GA # 527964
AMA Insurance Agency, Inc.
Name_____
Address_____
_____
City, State, Zip_____
Phone:_____
Email:_____

3. Payment Method

☐ Check (To IMG) ☐ Money Order (To IMG) ☐ Wire

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover ☐ JCB

eCheck (ACH) available online

By supplying my account information, I wish to pay the premium by credit card or the designated account for each applicant requesting coverage. If the application is accepted, the credit card or designated account will be billed for the premium at the selected payment mode. By signing and submitting this form, applicant represents and warrants that he/she has the card or account holder's authorization to use the account and, if not, will take full responsibility for the payment and any charges accruing to it. By submitting the signed application, I agree to pay via my credit card or applicable account the premium amount owed and have read and agree to all terms, conditions, and other statements in this application. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Card#_____Expiration date_____

Cardholder Name _____

Authorized Signature_____

Cardholder Phone & Email _____

Cardholder Billing Address _____

_____

SUBSCRIPTION I (we) hereby apply and subscribe to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for Student Health Advantage as underwritten and offered by Sirius International Insurance Corporation (publ) (the Company) on the date of receipt hereof and as administered by the Company's authorized representative and plan administrator, International Medical Group, Inc. (IMG). I (we) understand and agree: (i) the insurance applied for is not general health insurance, but is intended for my (our) use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) I (we) must pay premiums for the entire period of coverage in advance, and no coverage will be effective until this Application has been accepted in writing by the Company, (iii) no modification or waiver relating to this Application or the coverage applied for will be binding upon the Company or IMG unless approved in writing by an officer of the Company or IMG, and (iv) by submission of this application and/or any future claim for benefits I (we) purposefully initiate and take advantage of the privilege of conducting business with the Company in Indiana, through IMG as its managing general underwriter and plan administrator, and the contract of insurance represented by the Master Policy and evidenced by the Certificate of insurance will be deemed issued and made in Indianapolis, IN, and sole and exclusive jurisdiction and venue for any legal proceeding relating to this insurance will be in Marion County, Indiana, for which applicant(s) hereby consent(s). I (we) consent and agree that Indiana surplus lines law shall govern all rights and claims raised under the Certificate of Insurance.

ACKNOWLEDGEMENT I (we) understand and agree that: (i) the insurance producer/agent/broker soliciting, assigned to or assisting with this Application is the representative of applicant(s), (ii) this insurance does not provide benefits for any injury, illness, sickness, disease, or other physical, medical, mental or nervous disorder, condition or ailment that, with reasonable medical certainty, existed at the time of application or at any time during the 12 months prior to the effective date of the insurance, whether or not previously manifested, symptomatic or known, diagnosed, treated, or disclosed to the Company prior to the effective date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom (a "pre-existing condition"), and that all charges and/or claims incurred for pre-existing conditions will be excluded from coverage under this insurance, (iii) the subjects of insurance applied for are not intended or considered by the applicant(s), the Company or IMG to be resident, located, or expressly to be performed in any particular state of the United States, and (iv) the Company, as carrier and underwriter of the insurance plan, is solely liable for the coverages and benefits to be provided under the insurance contract.

AUTHORIZATION FOR RELEASE OF INFORMATION I (we) authorize any health plan, health care provider, health care professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to me or on my behalf, has any records or knowledge of my health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to disclose my entire medical record, file, history, medications, and any other information concerning me and to give any and all such information to my agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

CERTIFICATION I (we) hereby certify, represent and warrant that : (i) I (we) have read the foregoing statements and any marketing materials and sample insurance contract which were made available upon request and prior to the application or that they have been read to me (us), and I (we) understand them, (ii) I am (we are) eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) I am (we are) currently in good health and have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing or other medical condition which I (we) foresee may require treatment during this insurance or for which I (we) intend to claim under this insurance. If signed as the legal representative of the applicant, the signer warrants their authority and capacity to so act and to bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind applicant.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) I understand and agree that: (i) this insurance is not subject to, and does not provide benefits required by, PPACA, (ii) on January 1, 2014, PPACA requires U.S. citizens, U.S. nationals, and resident aliens to obtain PPACA compliant insurance coverage unless they are exempt from PPACA, and penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so, (iii) my eligibility to purchase, extend or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA, and (iv) I understand that it is solely my responsibility to determine if the insurance requirements are applicable to me, and the Company and IMG shall have no liability whatsoever, including for any penalties that any insured may incur, for a failure to obtain required or compliant coverage.

CERTIFICATION I (we) hereby certify, represent, and warrant that I (we) have read, or have had read to me (us), all statements on this application. I (we) represent that the responses are true, complete and correctly recorded; and that all travelers listed on this application are medically able to travel on the date this program is purchased. I (we) understand and agree that subject to your acceptance of this application and payment of the total amount due, coverage will begin at 12:01 a.m. on the day after this completed application is received and approved. I (we) understand that if premium is returned unpaid for any reason, coverage becomes null and void. I acknowledge and understand that if not completely satisfied after receiving the insurance contract, the insured person may request cancellation of the insurance retroactive to the effective date by sending a written request to the Company within the review period outlined in the insurance contract, and thereby receive a refund of premium paid. I wish to receive information and communicate electronically, and prefer to use my email address rather than regular mail. I agree IMG may provide me with any communications in electronic format, and IMG is not required to send paper communications to me, unless and until I withdraw this consent. I also agree it is my responsibility to provide IMG with true, accurate and complete e-mail address, contact, and other information related to my coverage, and to maintain and promptly update any changes in this information.

Signature of Primary Applicant or Legal Representative *(Required)*

_____

Date: _____