Global Mission Medical Insurance®

APPLICATION

Global Mission Medical Insurance is underwritten by Sirius International Insurance Corporation (publ) (the "Company"). It is distributed, managed and administered, as agent for and on behalf of the Company, by International Medical Group®, Inc. ("IMG®").

Important Information

Global Mission Medical Insurance offers two options: worldwide coverage or worldwide coverage excluding the U.S., Canada, China, Hong Kong, Japan, Macau, Singapore, and Taiwan. Both options provide coverage 24 hours a day, and you have the freedom to choose any doctor or hospital for treatment. Please note the risks and subjects of insurance under this plan are not intended or considered by the Company or IMG to be resident, located, or to be performed in any particular State of the United States, and special eligibility requirements apply.

Important Notice Regarding Patient Protection And Affordable Care Act (PPACA) Global Mission Medical Insurance is not subject to, and does not provide benefits required by, PPACA. On January 1, 2014, PPACA will require U.S. citizens and certain U.S. residents to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Tax penalties may be imposed on U.S. citizens and U.S. residents who are required to maintain PPACA compliant coverage but do not do so. Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely your responsibility to determine if PPACA is applicable to you. For information on whether PPACA applies to you or whether you are eligible to purchase Global Mission Medical Insurance, please see IMG's Frequently Asked Questions at www.imglobal.com/client-resources/PPACA-FAQ.aspx.

Also, this insurance is not subject to certain portability, access, renewal or other requirements of the Health Insurance Portability and Accountability Act of 1996. Please read and review all of the eligibility requirements, coverage conditions, and pre-existing condition exclusions carefully before purchasing coverage. Marketing brochures and certificate wordings containing complete terms of coverage are available upon request. Please contact IMG or your independent insurance agent/broker for details.

Directions for Completing the Application

[Failure to provide legible and complete information may delay processing of your Application.]

1. In Section 1, print or type your name and the names of all other family members applying for coverage as you want them to appear on your identification card(s). Also, please provide the complete address of your residence, and any mail forwarding address.
2. All applications must be fully completed, signed and dated to be considered. The application must be signed by the applicant, a guardian or proxy. A guardian must be legally authorized to sign on behalf of an applicant, especially a minor. A guardian would include a parent. A guardian's signature is required for any applicant under the age of sixteen (16). A proxy is a person authorized by the applicant to act on their behalf.

   A guardian or proxy that signs an application warrants their authority and capacity to sign for and bind the applicant. By accepting coverage and/or submitting a claim for benefits, the applicant ratifies the authority of the guardian or proxy to sign for and bind the applicant.
3. If any questions are answered "YES" in Section 2, you must identify the family member(s) to whom the "Yes" answer applies, and include the name, address and telephone number of the attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. (Please use the space provided in Section 3, entitled "Medical Information," to provide this information. Please attach additional pages as necessary).
4. ***U.S. Citizens*** – Eligibility: U.S. citizens must reside outside of the U.S. as of the effective date (or renewal date) and plan to reside outside of the U.S. for at least 6 of the next 12 months. The effective date of this insurance will be the later of: **a)** The effective date requested on the application; or **b)** The date that the insured person departs the U.S.; or **c)** The date that the application is accepted by IMG and a certificate of insurance is issued.

   Non-U.S. Citizens – Eligibility: Non-U.S. citizens must: **a)** reside outside the U.S. at the time of application (or renewal); or **b)** plan to reside outside the U.S. for at least 6 of the next 12 months and depart the U.S. within 30 days of your effective date (or renewal date); or **c)** if located in the U.S. at the time of application (or renewal) and do not plan to depart the U.S., provide IMG with an affidavit of eligibility. Your insurance agent/broker can assist you in this regard. A new affidavit of eligibility will be required at each renewal. For information on whether you are eligible to purchase Global Mission Medical Insurance, please see IMG's Frequently Asked Questions at www.imglobal.com/client-resources/PPACA-FAQ.aspx.
5. Annual premiums may be paid by check, money order, wire transfer or eCheck (available online); or by Visa, MasterCard, American Express, Discover or JCB credit cards. Except for Global Group, IMG will not accept checks, money orders or wire transfers for semi-annual, quarterly, or monthly payment modes. These alternative payment modes are only accepted with pre-authorization to debit your credit card on the due date(s) of your future premium installment(s), and result in total payments of 110%, 112%, and 120%, respectively, of the annual premium. An optional $25 fee may be paid in addition to the premium to have your insurance certificate express mailed to you after approval.

SECTION 1. Please complete for all Family Members applying for coverage

NAME Please print your name below	HEIGHT	WEIGHT	DATE OF BIRTH mo./day/yr.	COUNTRY OF CITIZENSHIP	GOVERNMENT ISSUED ID NUMBER
A. APPLICANT (LAST, FIRST, MIDDLE) ☐ MALE ☐ FEMALE					
B. SPOUSE (LAST, FIRST, MIDDLE) ☐ MALE ☐ FEMALE					
C. FIRST CHILD (BELOW AGE 19 - LAST, FIRST, MIDDLE) ☐ MALE ☐ FEMALE					
D. SECOND CHILD (BELOW AGE 19 - LAST, FIRST, MIDDLE) ☐ MALE ☐ FEMALE					
E. THIRD CHILD (BELOW AGE 19 - LAST, FIRST, MIDDLE) ☐ MALE ☐ FEMALE					

RESIDENCE ADDRESS	
STREET ADDRESS	
CITY	STATE, COUNTRY, POSTAL CODE
TELEPHONE	FAX
EMAIL	
Is your expected length of residence outside the U.S. at least 6 of the next 12 months? ☐ Yes ☐ No *(If a U.S. Citizen and you answered "No," you are not eligible for coverage. If a Non-U.S. Citizen and you answered "No," you must complete an Affidavit of Eligibility)*	
U.S. Citizens / U.S. Nationals:	
Date you did (or will) depart from the U.S. *(mo./day/yr.)*:	
Non-U.S. Citizens:	
If a non-U.S. citizen, do you or any other applicant have a Green Card or U.S. visa? If yes, please complete the following: **a.** Type of visa _____ **b.** Issue date _____ **c.** Expiration date_____ **d.** Date of arrival in U.S. _____	Green Card? ☐ Yes ☐ No U.S. Visa ☐ Yes ☐ No
MAIL FORWARDING ADDRESS *(IF DIFFERENT FROM ABOVE)*	
STREET ADDRESS	
CITY	STATE, COUNTRY, POSTAL CODE
TELEPHONE	FAX
EMAIL	
IF EITHER ADDRESS ABOVE IS IN FLORIDA, IS THE APPLICANT CURRENTLY LOCATED IN FLORIDA? ☐ YES ☐ NO (DETERMINES APPLICABLE PREMIUM TAX AND WILL NOT AFFECT COVERAGE)	

SECTION 2. Please answer all questions for the Applicant and for each Family Member applying for coverage

		IF YES, SHOW FAMILY MEMBER USING LETTERS FROM SECTION 1
1. Are you or any other applicant currently disabled or unable to perform any activity of daily living?	☐YES ☐NO	
2. Are you or any other applicant presently hospitalized, or scheduled for or in need of or been advised that you should have hospitalization or surgery?	☐YES ☐NO	
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	☐YES ☐NO	
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	☐YES ☐NO	
5. Do you participate in professional sports?	☐YES ☐NO	
If any individual answered YES to any of the above five questions, he or she does not qualify for this insurance. Thank you for your interest.		
6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please explain in Section 3.	☐YES ☐NO	
7. Are you or any other applicant currently pregnant? If yes, please provide due date: _____	☐YES ☐NO	

Questions 8 - 29, below must be answered for the applicant and every family member included on this Application. For any question answered "YES," please identify the family member to whom the answer applies (use the letter that corresponds to the family member from Section 1), and provide complete details of the medical condition at issue in the space provided in Section 3 of this Application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG and the Company reserve the right to request additional medical information.

Have you or any family member applying for coverage EVER experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:

8. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 3, please complete the following: **a)** Date of most recent blood pressure reading?_____ **b)** Most recent blood pressure reading: _____AS/_____DS **c)** Medications taken (Types and Dosage)_____	☐YES ☐NO	
9. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	☐YES ☐NO	
10. Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, in addition to Section 3, please complete the following: **a)** Diabetic Type: I_____ or II _____ **b)** Date diagnosed:_____ **c)** Controlled by diet only? Yes_____ No_____ **d)** Medications (Types and Dosage) _____ **e)** Date of most recent HbA1c Test?_____ **f)** Results of HbA1c Test (1 - 10)_____	☐YES ☐NO	
11. Asthma or allergies? If yes, in addition to providing explanation in Section 3, please specify which one and complete the following: **a)** Date diagnosed:_____ **b)** Has hospitalization or emergency room treatment been required? If yes, describe and list date(s):_____ **c)** Please list known triggers:_____ **d)** Medications (Types and Dosage):_____ **e)** Frequency of attacks:_____	☐YES ☐NO	
12. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind?	☐YES ☐NO	
13. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	☐YES ☐NO	
14. Kidney, urinary tract functions, kidney or bladder stones or infections?	☐YES ☐NO	
15. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	☐YES ☐NO	
16. Mental, emotional and/or nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, ADD or ADHD, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?	☐YES ☐NO	

SECTION 2. (continued)

	IF YES, SHOW FAMILY MEMBER USING LETTERS FROM SECTION 1	
17. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	☐YES ☐NO	
18. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	☐YES ☐NO	
19. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, and/or disorders of the reproductive system or of menstruation, including but not limited to: vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus, and hormone replacement therapy?	☐YES ☐NO	
20. For male applicants, disorders of the reproductive system, including but not limited to: prostate or elevated PSA level, or erectile dysfunction?	☐YES ☐NO	
21. Congenital, genetic, hereditary or other birth condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	☐YES ☐NO	
22. Digestive system, stomach, colon, rectum or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, Crohn's Disease and/or diverticulitis?	☐YES ☐NO	
23. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	☐YES ☐NO	
24. Do you or any family member applying for coverage currently use or during the past five years have used tobacco in any form?	☐YES ☐NO	
25. Any other disease, medical problem, illness, injury or condition of any kind not listed above?	☐YES ☐NO	
26. During the last twelve (12) months, have you or any family member applying for coverage experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please explain in Section 3.	☐YES ☐NO	
27. Have you or any family member applying for coverage ever applied for or purchased insurance through IMG? (If yes, please provide certificate number, if any, and details.)	☐YES ☐NO	
28. Have you or any family member applying for coverage ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy? If yes, please explain in Section 3.	☐YES ☐NO	
29. During the last twelve (12) months, have you or any family member applying for coverage been covered under any health or medical insurance plan, including a government sponsored health care plan? If yes, please state the name and location of the insurance company, the policy/plan number, and the applicable dates of coverage.	☐YES ☐NO	

SECTION 2a. **Please list all prescribed and over the counter medications, and any medical treatment in the last twelve months for the Applicant and for each Family Member for whom it applies (use the corresponding letter(s) from Section 1). Please attach additional pages as necessary.**

Family Member *(use letters from Section 1)*	**Medications and Dosages**	**Conditions**	**Date(s) of Treatment**

Family Member *(use letters from Section 1)*	**Surgeries**	**Date(s) of Treatment**

Family Practitioner's Details - The following information must be completed	
Doctor's Name:	Telephone:
Address:	
Country:	Postal/Zip Code:
Date Last Seen:	Reason:

SECTION 3. Medical Information/Prior Insurance

For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. ***Please attach additional pages as necessary.*** IMG and the Company reserve the right to request additional medical information prior to acceptance of Application.

Family Member *(use letters from Section 1)*	**Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)**	**Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone**	**Date(s) of Treatment**

If any family member applying for coverage has ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy (see Question 28), please explain below.

SUBSCRIPTION I (we) hereby apply to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for Global Mission Medical Insurance® as offered by the Company on the date of its receipt hereof. I (we) understand and agree that: (i) no coverage will be effective until this Application has been duly accepted in writing by the Company, (ii) 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, (iii) IMG and the Company will rely on the accuracy and completeness of the information provided herein, (iv) any misrepresentation or omission contained herein will void the insurance certificate, and any and all claims and benefits thereunder will be forfeited and waived, (v) 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 selected agent and administrator, and invoke the benefits and protections of its laws, and (vi) the contract of insurance represented by the Master Policy and evidenced by the Certificate of insurance shall be deemed issued and made in Indianapolis, IN, and sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Marion County, Indiana, for which applicant(s) hereby consent(s). I (we) agree that Indiana surplus lines law shall govern all rights and claims arising under this insurance, and trial of any dispute shall be by the court as fact finder, without a jury.

ACKNOWLEDGEMENT I (we) understand and agree that: (A)(i) marketing brochures and certificate wordings are available prior to application upon request, (ii) the insurance agent, broker, website, or other producer, if any, involved with respect to the solicitation of this application is acting solely as my legal agent and representative and is representing my personal interests, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of, the Company or IMG, (iii) any illness, Injury, 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 prior to the effective date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, treated, or disclosed to the Company or IMG prior to the effective date, and including any and all chronic, subsequent or recurring complications or consequences related thereto or resulting or arising therefrom (a "pre-existing condition"), and on certain plan options, will be excluded from coverage for two years from the effective date, and thereafter will be limited to $50,000 lifetime per person, with a maximum of $5,000 per person per annual coverage period, (iv) any existing condition/diagnosis/illness that is not disclosed on my application would never be covered under this certificate or renewal, (v)the subjects of insurance applied for are not intended or considered by the applicant(s), the Company or IMG to be resident, located, or to be performed in any particular state of the United States, or any country, and (vi) the Company, as carrier and underwriter of the plan, is solely liable for the coverages and benefits to be provided thereunder, and IMG acts solely as agent for the Company and has no direct or independent liability under the Master Policy or any Certificate of insurance.
(B) This insurance is not subject to, and does not provide benefits required by, PPACA. On January 1, 2014, PPACA will require U.S. citizens, U.S. nationals and certain U.S. residents to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so. 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. Please note that it is an insured person's sole and exclusive responsibility to determine if PPACA is applicable to them, and the Company and IMG shall have no liability to any person whatsoever for their failure to obtain or maintain PPACA compliant insurance coverage. For information on whether PPACA applies to you or whether you are eligible to purchase Global Mission Medical Insurance, please see IMG's Frequently Asked Questions at www.imglobal.com/client-resources/PPACA-FAQ.aspx.

CERTIFICATION I (we) hereby certify, represent and warrant to IMG and the Company that: (i) I (we) have read the questions contained in this Application or they have been read to me (us), and I (we) understand them, (ii) my (our) responses to the questions are true, accurate and complete in all respects as of the date hereof, and that I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto, (iii) I am (we are) currently in good health and, except for the conditions and other information disclosed herein, I (we) 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 condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance, and (iv) if this Application is signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and 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 the applicant.

MEDICAL RELEASE I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health care related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, and/or employment status, to provide such information to IMG and/or the Company and my producer/broker involved in procurement of this application and/or insurance coverage.

SATISFACTION GUARANTY/REVIEW PERIOD It is understood I (we) will have 15 days from the effective date to review the insurance Certificate and all benefits, terms, conditions, limitations and exclusions of coverage. If not completely satisfied, I (we) may cancel this insurance by written request retroactive to the effective date and receive a full refund of premium.

Signature of Applicant, Guardian or Proxy* *(Relationship to Applicant if signing as Guardian or Proxy)* **Date (Mo./Day/Yr.)**

Signature of Spouse **Date (Mo./Day/Yr.)**

**A guardian's signature is required for any applicant under the age of sixteen (16). See Directions for Completing the Application, Page 1, number 2, regarding Guardian or Proxy signatures.*

GLOBAL TERM LIFE INSURANCE℠
GLOBAL DAILY INDEMNITY℠

Underwritten by International Medical Insurance Company℠, Inc. (IMIC℠). It is distributed, managed and administered, as agent for IMIC, by International Medical Group®, Inc. ("IMG®"). Global Term Life Insurance and Global Daily Indemnity are only available at the time of application for, and with the purchase of, Global Mission Medical Insurance®.

SECTION 4.

Please indicate the name of each Family Member applying for these optional plans

NAME	TERM LIFE UNIT ONE	TERM LIFE UNIT TWO	INDEMNITY UNIT ONE	INDEMNITY UNIT TWO
A. APPLICANT	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
B. SPOUSE	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
C. FIRST CHILD	☐YES ☐NO	**NOT AVAILABLE**	☐YES ☐NO	☐YES ☐NO
D. SECOND CHILD	☐YES ☐NO		☐YES ☐NO	☐YES ☐NO
E. THIRD CHILD	☐YES ☐NO		☐YES ☐NO	☐YES ☐NO

FOR EACH INDIVIDUAL APPLYING FOR LIFE INSURANCE, PLEASE INDICATE:		% OF DEATH BENEFIT
APPLICANT A PRIMARY BENEFICIARY NAME CONTINGENT BENEFICIARY NAME	RELATIONSHIP RELATIONSHIP	%
APPLICANT B PRIMARY BENEFICIARY NAME CONTINGENT BENEFICIARY NAME	RELATIONSHIP RELATIONSHIP	%
APPLICANT C PRIMARY BENEFICIARY NAME CONTINGENT BENEFICIARY NAME	RELATIONSHIP RELATIONSHIP	%
APPLICANT D PRIMARY BENEFICIARY NAME CONTINGENT BENEFICIARY NAME	RELATIONSHIP RELATIONSHIP	%
APPLICANT E PRIMARY BENEFICIARY NAME CONTINGENT BENEFICIARY NAME	RELATIONSHIP RELATIONSHIP	%

If a U.S. citizen, I (we) understand coverage for Global Term Life Insurance will not be effective prior to the date of my (our) departure from the U.S.

x_____ (initial here) Applicant
x_____ (initial here) Spouse
x_____ (initial here) For Covered Children

If accepted for the Global Mission Medical Insurance plan, I (we) understand that I (we) may qualify for Global Term Life Insurance and/or Global Daily Indemnity underwritten by International Medical Insurance Company. I (we) do hereby apply to the Global Life Insurance Services Group Insurance Trust, Bank of Bermuda, Hamilton, Bermuda, for Global Term Life Insurance and/or Global Daily Indemnity, as indicated above. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorizations, and warranties from the foregoing Application for Global Mission Medical Insurance, and understand and agree that the terms, conditions, restrictions and penalties thereof shall likewise apply hereto. If I (we) have also applied for the optional Global Daily Indemnity plan, I (we) understand that only overnight hospital stays eligible under my (our) Global Mission Medical Insurance plan, excluding pregnancies, are covered. I (we) also understand: (i) there is an additional premium for Global Daily Indemnity, (ii) that in the event IMG does not accept this Application, its sole obligation is to return the premium to me (us), (iii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iv) that the Master Policy for Global Term Life Insurance and Global Daily Indemnity is issued in Bermuda and is governed by its laws.

Signature of Applicant, Guardian or Proxy	Date (Mo./Day/Yr.)	Signature of Spouse	Date (Mo./Day/Yr.)

SECTION 5.

Deductible Selection and Premium Calculation. Note: Plan Option, Deductible Selection, Payment Mode, and Area of Coverage must be the same for all Family Members.

Check one Plan Option:	☐ **Silver** ☐ **Gold** ☐ **Gold Plus** ☐ **Platinum**
Check one Deductible:	☐ **$100** *(Platinum only)* ☐ **$250** ☐ **$500** ☐ **$1,000** ☐ **$2,500** ☐ **$5,000** ☐ **$10,000**
Check one Payment Mode:	☐ **Annual = 1.00** ☐ **Semi-annual = 0.55** ☐ **Quarterly = 0.28** ☐ **Monthly = .10**
Check one Area of Coverage:	☐ **Worldwide** ☐ **Worldwide excluding the U.S., Canada, China, Hong Kong, Japan, Macau, Singapore, and Taiwan**

PREMIUM CALCULATION (Applications without payment of premium will not be approved)
Annual premiums may be paid by check, money order, wire transfer or eCheck (available online); or by Visa, MasterCard, American Express, Discover or JCB credit cards. Except for Global Group, IMG will not accept checks, money orders or wire transfers for semi-annual, quarterly, or monthly payment modes. **These alternative payment modes are only accepted with pre-authorization to debit your credit card on the due date(s) of your future premium installment(s) prior to the expiration date.** An optional $25 fee may be paid in addition to the premium to have your insurance certificate express mailed to you after approval.

Enter the ***annual*** Global Mission Medical Insurance premium for each Family Member that corresponds to their age, gender and deductible.

Application cannot be processed unless this section is completed.

Primary Applicant $_____
Spouse $_____
1st Child $_____
2nd Child $_____
3rd Child $_____
GMMI Subtotal $_____

Optional Benefits

Terrorism Rider - ☐
(Platinum plan option only. Check the box and enter .25 to the right of the 1. if applicable) X **1.**_____

GMMI Subtotal A = $_____

Term Life Unit One $240 X_____ = **B** $_____
# of adults applying

Term Life Unit Two $180 X_____ = **C** $_____
# of adults applying

Term Life Unit One - Child $100 X_____ = **D** $_____
# of children applying

Daily Indemnity Unit One $100 X_____ = **E** $_____
# of family members applying

Daily Indemnity Unit Two $100 X_____ = **F** $_____
# of family members applying

Optional Maternity Rider Enter $4,000 here **G** $_____
(Applies only to Silver, Gold and Gold Plus plan options)

Dental & Vision Rider
$570 *(worldwide)* or $460 *(worldwide excluding)* X_____ = **H** $_____
(Applies only to Silver, Gold and Gold Plus plan options) # of family members applying

Optional Sports Rider $250 X_____ = **I** $_____
(Applies only to Gold Plus and Platinum plan options) # of family members applying

Subtotal (A+B+C+D+E+F+G +H+I) = J $_____

Total Premium Due

$_____ X _____ + $_____ =
Subtotal J Modal Factor Optional Express Mail*

K $_____
Premium Amount Due

Modal Factors: Annual=1.00 Semi-Annual=.55
Quarterly=.28 Monthly=.10

Note: Choosing the semi-annual payment option (modal payment factor .55) results in total payments of 110% of the annual premium, choosing the quarterly payment option (modal payment factor .28) results in total payments of 112% of the annual premium, and choosing the monthly payment option (modal payment factor .10) results in total payments of 120% of the annual premium.

*Optional $25 Express mail - Certificate(s) will be expressed mailed to you after approval

IF YOU CHOOSE EXPRESS MAIL - Please select the address where you would like your Certificate express mailed (as indicated in Section 1)
☐Residence address ☐Mail forwarding address
☐Other (no P.O. boxes please)_____

☐**I WOULD PREFER TO RECEIVE AN ELECTRONIC CERTIFICATE**
Email address _____

METHOD OF PAYMENT

☐Check (annual only) ☐Money Order (annual only)
☐Wire (annual only) ☐MasterCard ☐Visa
☐American Express ☐Discover ☐JCB
☐Global Group (complete additional insert)
Group Name:_____

eCheck (ACH) available online

(Authorized signature required for credit card payments)

Checks and money orders should be made payable to International Medical Group, Inc. (IMG). For wire transfer information, please contact IMG. All payments must be made in U.S. dollars and drawn on a U.S. bank at the time application for coverage is made. If paying by credit card, I authorize IMG to debit my Visa/MasterCard/American Express/Discover/JCB credit card account for the total amount due. In the event that I have chosen a semi-annual, quarterly, or monthly modal factor, ***I hereby elect to pre-authorize future credit card payment installments for the balance of the annual period of coverage (12 months from the Effective Date), and hereby request and authorize IMG to charge my credit card periodically as payment installments become due for premiums. This authorization will remain in effect for 12 months, unless earlier revoked by me in writing and IMG actually receives notice of revocation, whereupon continuing coverage may be impacted.*** Coverage purchased by credit card is subject to validation and acceptance by credit card company.

Credit Card #_____

Exp. Date _____
(cannot be earlier than last premium installment due date)

Authorized Signature X_____

Name as it appears on card_____

_____

Daytime Phone# (_____)_____

Billing Address_____

_____

REQUESTED EFFECTIVE DATE:_____
(Must be within 30 days after signature. Coverage will in no event be effective until approved.)

SECTION 6. Renewal Contact Information

Please specify the best way to contact you at renewal:

☐ Mail (please provide address)_____

☐ Fax (please provide fax number)_____

☐ Email (please provide email address)_____

SECTION 7. Insurance Agent/Broker Use Only

IMG Agent/Broker Number #	Agent/Broker Name
Company Name	
Address	
City, State, Zip	Phone
Fax	Email Address
Website	
Agent/Broker Signature X	GA #

Please mail or fax this application to:
International Medical Group, Inc.
P.O. Box 88509
Indianapolis, IN 46208-0509 USA

Call direct 1-317-655-4500 or
toll free (in U.S.) 1-800-628-4664
Fax 1-317-655-4505
www.imglobal.com

Address change information or additional contact information should also be directed to IMG.

© 2007-2014 International Medical Group, Inc. All rights reserved.