CREW SELECT INTERNATIONAL
APPLICATION

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Underwritten by Sirius International Insurance Corporation (publ) (the "Insurer"). It is distributed, managed and administered, as agent for and on behalf of the Insurer, by International Medical Group®, Inc. ("IMG®"). Coordinated, as agent for and on behalf of the Insurer for the purposes of receiving premiums, receiving and holding claims money; and receiving and holding premium refunds, by IMG Europe Ltd.

Important Information

CrewSelect International provides you with cover 24 hours a day, and you have the freedom to choose any doctor or hospital for treatment within your area of coverage. Please note the risks and subjects of insurance under this plan are not intended or considered by the Insurer or IMG or IMG Europe Ltd. to be resident, located, or to be performed in any particular State of the USA, or any particular country, and special eligibility requirements apply. Also, this insurance is not subject to certain portability, access, renewal or other requirements of the Health Insurance Portability and Accountability Act of 1996 (USA). Please read and review all of the eligibility requirements, cover conditions, and pre-existing condition exclusions carefully before purchasing cover. Marketing brochures and Policy Wordings containing complete terms of cover are available upon request. Please contact IMG Europe Ltd. or your independent insurance agent/broker for details.

Directions for Completing the Application

Please complete this form in block capitals using black ink. For all sections please ensure you give an answer to every question. Failure to provide legible and complete information will delay the processing of your Application.

1. In Section 1, print or type your name as you want it to appear on your identification card. Also, please provide the complete address of your residence outside the USA, and any mail forwarding address.

2. All Applications must be fully completed, signed and dated to be considered. If any questions are answered "YES" in Section 2, you must 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).

3. USA Citizens: If you or any family member applying for cover are located in the USA on the date of this application, the effective date of this insurance, if issued, will be the later of:

a) The effective date requested on the application; or
b) The date the insured person departs the USA; or
c) The date the application is accepted by IMG Europe Ltd. and a Certificate of Insurance issued.

If you are a USA citizen, you must not qualify for or be able to obtain adequate cover under a USA domestic insurance plan that will provide continuous cover outside of the USA, and you must provide a signed Statement of Residence and an address of residence outside of the USA, if available.

Non-USA Citizens: You must provide a residence address outside of the USA. If you do not have a residence outside of the USA, then you must sign and submit to IMG Europe Ltd. a Statement of Residence form.

4. Annual premiums may be paid by Visa, MasterCard or American Express credit/debit cards, bank transfer or bankers draft. IMG Europe Ltd. will not accept cheques, bank transfers or bankers drafts for semi-annual, quarterly, or monthly payment frequencies. These alternative payment modes are only accepted with pre-authorisation to debit your credit card on the due date(s) of your future premium instalment(s), and result in total payments of 110%, 112%, and 120%, respectively, of the annual premium. An optional £15/$25/€18 fee may be paid in addition to the premium to have your insurance certificate express despatched to you after approval.

Section 1. Please complete all requested information

NAME Please print your name below	HEIGHT	WEIGHT	DATE OF BIRTH (DD/MM/YY)	COUNTRY OF CITIZENSHIP	GOVERNMENT ISSUED ID NUMBER
Applicant (Last, First, Middle): ☐MALE ☐FEMALE	cm ☐ in ☐	kg ☐ lbs ☐			

Name of Current or Most Recent Vessel **(required information):**

Country of Registry **(required information):**

Telephone:	Vessel Fax (if applicable):

Vessel Email (if applicable):

Please Check the Best Way to Contact You at Renewal:

☐ Personal Email ☐ Vessel Email ☐ Vessel Fax ☐ Personal Fax ☐ Post

RESIDENCE ADDRESS

I Reside on Board the Vessel Where I Work: ☐ YES ☐ NO

Street Address:

Town/City:	State/County:	Postal Code:	Country:

Primary Telephone: +(Country) (Area) Number	Other Telephone: +(Country) (Area) Number
Email:	Fax: +(Country) (Area) Number

Is Your Expected Length of Residence Outside the USA at Least 6 of the Next 12 Months? ☐ YES ☐ NO
(If you answer No, you are ineligible for this product)

USA Citizens - Date You Did (or Will) Depart from the USA (DD/MM/YY) _____/_____/_____ Note: You Must Provide a Statement of Residence	**Non-USA Citizens** - If Your Residence Address is in the USA and You Answered "No" to the Question Above, or the Residence Address is Not Completed, a Statement of Residence Must be Completed.

MAIL FORWARDING ADDRESS

Street Address:

Town/City:	State/County:	Postal Code:	Country:

Telephone: +(Country) (Area) Number	Fax: +(Country) (Area) Number

Email:

If Either Address Above is in Florida, is the Applicant Currently Located in Florida? ☐ YES ☐ NO
(Determines Applicable Surplus Lines Tax and Will Not Affect Cover)

❑ **I AGREE TO THE PROCESSING OF MY PERSONAL INFORMATION, INCLUDING FOR CUSTOMER SERVICE AND MARKETING COMMUNICATIONS, IN ACCORDANCE WITH IMG'S PRIVACY POLICY (WWW.IMGLOBAL.COM/LEGAL/PRIVACY-POLICY)**

Section 2. Please answer all questions

1. Are you currently disabled or unable to perform normal activities?	☐YES ☐NO
2. Are you presently hospitalised, or scheduled for or in need of hospitalisation or surgery?	☐YES ☐NO
3. Have you 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 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 you answered YES to any of the above five questions, we regret that you do not qualify for this insurance. Thank you for your interest.	
6. Have you been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please complete Section 3.	☐YES ☐NO
7. If a non-USA citizen, do you or any other applicant have a USA visa or green card? If yes, please complete the following: **a.** Type of visa _____ **b.** Issue date _____ **c.** Expiration date _____ **d.** Date of arrival in USA _____	☐YES ☐NO
8. Are you currently pregnant? If yes, please provide due date: _____	☐YES ☐NO
If you answered YES to any of the above three questions, you may not qualify for this insurance.	

Questions 9 - 31, below must be answered. For any question answered "YES," please provide the 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 Europe Ltd. and the Insurer reserve the right to request additional medical information.

Have you 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:

9. 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
10. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anaemia, haemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	☐YES ☐NO
11. 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
12. Asthma or allergies? If yes, in addition to Section 3, please specify which one and complete the following: **a)** Date diagnosed:_____ **b)** Has hospitalisation 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
13. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind?	☐YES ☐NO
14. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	☐YES ☐NO
15. Kidney, urinary tract functions, kidney or bladder stones or infections?	☐YES ☐NO
16. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	☐YES ☐NO
17. Mental and 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)	
18. 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
19. 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
20. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment, and disorders of the reproductive systems, including but not limited to: vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus, and hormone replacement therapy?	☐YES ☐NO
21. For male applicants, disorders of the reproductive systems, including but not limited to: prostate or elevated PSA level, or erectile dysfunction?	☐YES ☐NO
22. 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
23. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	☐YES ☐NO
24. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	☐YES ☐NO
25. Any other disease, medical problem, illness, injury or condition of any kind not listed?	☐YES ☐NO
26. Do you currently use or during the past five years have you used tobacco in any form?	☐YES ☐NO
27. Have you ever applied for or purchased insurance through IMG? (If yes, please provide certificate number, if any, and details.) Certificate Number:_____ Policy Undertaken:_____	☐YES ☐NO
28. During the last twelve (12) months, have you 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 complete Section 3.	☐YES ☐NO
29. Have you ever been rejected, cancelled, rated or declined for cover under any health, life or disability insurance policy? If yes, please explain in Section 3.	☐YES ☐NO
30. I certify that I am a Professional Marine Crew Member who currently or usually works aboard a vessel as a full-time seagoing crew member. I expect to spend a significant period sailing outside of USA waters and I do not qualify for adequate cover under a USA domestic insurance plan.	☐YES ☐NO
31. During the last twelve (12) months, have you 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 cover:_____	☐YES ☐NO

SECTION 2a. Please list all prescribed and over the counter medications, and any surgeries. Please attach additional pages as necessary.

Medications and Dosages	Conditions	Date(s) of Treatment

Surgeries	Date(s) of Treatment

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

Section 3. Medical Information / Prior Insurance

For any question answered "YES" in Section 2, please 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 Europe Ltd. and the Insurer reserve the right to request additional medical information prior to acceptance of Application.

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 you have ever been rejected, cancelled, rated or declined for cover under any health, life or disability insurance policy (see Section 2, Question 29), please explain below.

Declaration for CrewSelect International

AGREEMENT

I (we) understand and hereby agree that:

i. I (we) apply for insurance under CrewSelect International cover.

ii. Cover will be provided in accordance with the Policy Wording; and I (we) will read it upon receipt and be bound by it unless I (we) cancel the plan within 30 days after receiving the Policy Wording.

iii. This Application will be the basis for and form a part of any insurance issued.

iv. I (we) have read all statements, questions and responses contained in this Application or they have been read to me (us) and I (we) understand them.

v. My (our) responses to the statements and questions contained in this Application are true, accurate complete and correctly recorded in all respects, and I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto.

vi. The agent/broker assigned to or assisting with this Application is the representative of me (us) and is not an agent/broker of the Insurer, IMG or IMG Europe Ltd.

vii. No agent/broker has the authority to modify or waive any statement, question or response in this Application or to modify or waive any term of the plan, or to waive any of the rights or requirements of the Insurer, IMG or IMG Europe Ltd.

viii. No cover will be effective unless and until this Application has been duly accepted in writing by the Insurer, and there has been no change since the date of this Application Form in the insurability of all persons proposed for cover or in any responses to the statements and questions in this Application.

ix. The subjects, risks and benefits of insurance for which I (we) apply for cover under the plan are not intended or considered by me (us) to be resident, located or performed in any state of the USA or any particular country.

x. Premiums will be applied from the effective date forward and there will be no cover for any claim that begins prior to the effective date.

xi. Any misstatement, misrepresentation or omission contained in this Application will void the insurance applied for, and any and all claims and benefits under the plan will be forfeited and waived.

xii. The Insurer, IMG and IMG Europe Ltd., their employees, representatives, agents and any other persons or organisations performing services for them or on their behalf, may use, disclose or transfer to any organisation any information about me (us) obtained or collected in connection with this Application, (whether contained in this Application or otherwise) for the purpose of: (1) assessing this Application and providing on-going insurance and customer service; (2) processing and giving effect to credit/debit card payments; (3) providing marketing material in respect of insurance related services of IMG or its associated companies; (4) processing claims or analysing the insurance; (5) the identification and prevention of fraud and crime.

AUTHORISATION

For purposes of determining my (our) insurability, I (we) authorise any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, pharmacy, medical records service, prescription history clearinghouse, other insurer, government agency, employer, social worker or family member to provide information about me (us), including my (our) entire medical record, to Sirius International Insurance Corporation (publ), International Medical Group, Inc. and IMG Europe Ltd., their employees, representatives, agents and any other persons or organisations performing insurance services for them or on their behalf. By my (our) signature below, I (we) acknowledge that any prior agreement I (we) have made to restrict or limit the disclosure of information about my (our) health does not apply to this authorisation.

This authorisation is valid from the date of my (our) signature shown below. A copy, image or facsimile of this authorisation is as valid as the original.

Signature of Applicant **X**: ***(Must be signed and dated)***	Date: DD/MM/YY

Section 4 - Optional Additional Covers Application Form.
Global Personal Accident Plan / Global Daily Indemnity[SM] - Hospital Income Plan

Global Personal Accident Plan and Global Daily Indemnity are only available at the time of application for, and with the purchase of, CrewSelect International. To apply, simply complete this section.

Underwritten by Sirius International Insurance Corporation (publ) (the "Insurer"). Administered, as agent for and on behalf of the Insurer, by International Medical Group, Inc. ("IMG"). Coordinated, as agent for and on behalf of the Insurer for the purposes of receiving premiums, receiving and holding claims money, and receiving and holding premium refunds by IMG Europe Ltd.

Name	Personal Accident First Unit of Cover	Personal Accident Second Unit of Cover	Daily Indemnity First Unit of Cover	Daily Indemnity Second Unit of Cover
Applicant:	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO

Beneficiary information need only be completed if applying for Global Personal Accident Plan	% of Death Benefit
Primary Beneficiary Name: Relationship: Phone No. + ( )	%
Contingent Beneficiary Name: Relationship: Phone No. + ( )	%

Declaration for Global Personal Accident Plan and/or Global Daily Indemnity (If Applicable)

If accepted for the CrewSelect International, I (we) understand that I (we) may qualify for Global Personal Accident Plan and/or Global Daily Indemnity underwritten by Insurer. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorisations, and warranties from the foregoing Application for the CrewSelect International, and understand and agree that the terms, conditions, restrictions and penalties thereof shall likewise apply hereto. If a USA citizen, I (we) understand cover for Global Personal Accident Plan will not be effective prior to the date of my (our) departure from the USA 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) CrewSelect International, excluding pregnancies, are covered. I (we) also understand: (i) there is an additional premium for Global Daily Indemnity, (ii) that in the event this Application is not accepted, the premium will be returned to me (us) and neither party will have any obligation, right or liability under the plan, (iii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iv) that the Global Personal Accident Plan and Global Daily Indemnity are issued in England and are governed by the Laws of England.

Signature of Applicant **X**:	Date: DD/MM/YY

Section 5i. Selection of Plan and Cover Details - Please select the Plan, Currency, Excess and Area of Cover you are applying for (tick one box only in each section below).

Tick One Plan: ☐ Standard ☐ Elite

Tick One Currency: ☐ £GBP ☐ $USD ☐ €EURO

Tick One Excess: ☐ Nil ☐ £25/$40/€30 (Elite Only) ☐ £50/$85/€60 ☐ £100/$170/€120 ☐ £250/$425/€295
☐ £500/$850/€600 ☐ £1,000/$1,700/€1,200 ☐ £2,500/$4,250/€2,950 ☐ £5,000/$8,500/€6,000 ☐ £10,000/$17,000/€11,800

Tick One Area of Cover: ☐ Area 1 - Europe ☐ Area 3 - Worldwide
☐ Area 2 - Worldwide excluding the USA, Canada, China, Hong Kong, Japan, Macau, Singapore, and Taiwan

Section 5ii. Method and Frequency of Payment - Please choose your method and frequency of payment. The currency you have selected for your plan will also be the currency in which your premium is to be paid. Your currency selection cannot be altered at renewal or a later date.

☐ **A. Credit Card -** Please Tick Only One Frequency of Payment. *Note: Choosing the semi-annual payment option results in total payments of 110% of the annual premium, choosing the quarterly payment option results in total payments of 112% of the annual premium, and choosing the monthly payment option results in total payments of 120% of the annual premium.*

☐ Annually	☐ Semi-Annually	☐ Quarterly	☐ Monthly

Your Credit/Debit Card Details

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express

Full Card Number:

Start Date:	Expiry Date:	Issue No.:_____ Issue Date:_____ (if applicable)	Security Number:_____ (last 3 digits on signature strip or 4 printed on front of AMEX)

Name as on card:

Address to which card is registered:
(if different from the mailing address given)

Daytime Telephone: +(Country) (Area) Number

If paying by credit/debit card, I authorise IMG Europe Ltd. to debit my credit/debit card account above for the total amount due (including any insurance premium taxes if applicable). In the event that I have chosen a semi-annual, quarterly, or monthly payment frequency, I hereby elect to pre-authorise future credit card payment installments for the balance of the annual period of cover (12 months from the Effective Date), and hereby request and authorise IMG Europe Ltd. to charge my credit card periodically as payment installments become due for premiums. This authorisation will remain in effect for 12 months, unless earlier revoked by me in writing and IMG Europe Ltd. actually receives notice of revocation, whereupon continuing cover may be impacted. At all subsequent renewals, I authorise IMG Europe Ltd. to collect the renewal premiums due at that time, on the same payment frequency basis as the previous year until I give written notice that I wish to terminate this agreement. Cover purchased by credit card is subject to validation and acceptance by a credit card company. I understand that I will be given advance notice of the renewal premiums and that they may vary each year.

Cardholder's Signature **X** Date: DD/MM/YY

☐ **B. Bank Transfer (Annual Premium Payments Only) -** If paying by bank transfer or cheque: To avoid delays, we recommend you check your premium calculation and any taxes (if applicable) with us or your broker.

Once your Application has been processed, the necessary bank transfer information will be forwarded to you and your payment is required within 10 days. [Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on any transfer.] Liability for any bank transfer which does not clearly identify the proposer will not be accepted by the Insurer, IMG or IMG Europe Ltd.

☐ **C. Bank Cheque / Bankers Draft / Money Order**** (Annual Premium Payments Only)

Please make payable to: **IMG Europe Ltd.**	Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on the reverse of the cheque. ** UK£ Cheque for sterling contract, US$ cheque for dollar contract or Euro cheque for Euro€ contract

INTERNAL USE ONLY

(_____ X _____) x _____ = _____ + _____ + _____ = _____

Total Medical Premium | Excess Rate factor | Modal/Instalment factor | Optional Cover Premium | Insurance Premium Taxes/Levies | Total Premium Due

SECTION 6. Requested Start Date			
Date on which you wish your CrewSelect International cover to commence:	❑ On Acceptance	❑ Other / /	*(Must be within 30 days after signature. Cover will in no event be effective until approved.) Please note we cannot commence your plan until we have accepted your Application and received your first or annual premium payment)*

SECTION 7. Renewal Contact Information: Please specify the best way to contact you when it comes to renewing your cover:

❑ Mail - Please provide address:

❑ Fax - Please provide fax number:

❑ Email - Please provide email address:

Policy Fulfillment & Despatch Options: Please tick one of the following to indicate how you would like your Certificate of Insurance and Supporting Policy documentation sent to you.

❑ Electronic E-mail Despatch:	Certificate of Insurance and supporting documentation sent direct to your email address and no documentation will be sent by post. Please select the email address from Section 1 in which you wish to have documentation sent: ❑ Vessel ❑ Mail Forwarding ❑ Residence
❑ Standard Mail Despatch:	Paper Certificate of Insurance and printed supporting documentation will be mailed to your Mail Forwarding Address shown in Section 1 by regular international air-mail.
❑ Express Mail Despatch:	Paper Certificate of Insurance and printed supporting documentation will be mailed to you by EXPRESS international air-mail. Please note there will be an additional fee of £15/$25/€18 to be paid in addition to the premium to have your Certificate of Insurance express air-mailed to you after approval. (Confirm despatch address below.)

Express Mail Despatch Address Details: If you have selected Express Mail Despatch above, please select the address where you would like your Certificate of Insurance and supporting documentation mailed to (as indicated in Section 1) - Tick One Only:

❑ Residence Address ❑ Mail Forwarding Address ❑ Other (No P.O. Boxes please) _____

SECTION 8. Insurance Advisor / Broker Use Only	
IMG Producer Number:	Phone: +(Country) (Area) Number
Company Name:	Fax: +(Country) (Area) Number
Contact Name or Stamp:	Email:
GA # (If Applicable):	Website:

Please mail or fax this application to:

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

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