Patriot Exchange Program - Group Application *(For groups of five or more)*

To Enroll -

1. Complete all sections and sign 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 to: International Medical Group, Inc., P.O. Box 88509, Indianapolis, IN 46208-0509 USA, Fax 1.317.655.4505 Email: insurance@imglobal.com

1.	Participants applying for coverage	Country of Citizenship & Country of Residence	Date of Birth	Government Issued ID Number	Participant's requested EFfective date, EXpiration date and/or DEparture date, if different than group	Monthly premium rate/ monthly Add-On rate
☐1	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX: DE:	
☐2	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX: DE:	
☐3	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX: DE:	
☐4	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX: DE:	
☐5	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX: DE:	

(Attach additional sheets if necessary)

▲ Check the box in front of the applicant who will be the Chaperone/Program Leader ***(if the Chaperone rider is selected)***

Please note: If the applicant is a J2 visa holder, he/she is only eligible for this plan if the J1 visa holder is insured under a plan through his or her program.

SUBTOTAL A: _____

2. _____ **X** _____ **=** _____
Subtotal A **# of months** **Total (A)**

Select the area of coverage

- ☐ **Non-U.S. citizens - Worldwide coverage except home country**
- ☐ **U.S. citizens - Worldwide coverage except U.S.**
- ☐ **Non-U.S. citizens - Travel to Europe only**

Select the plan option (maximum limit per illness/injury)

- ☐ **$50,000**
- ☐ **$100,000**
- ☐ **$250,000**
- ☐ **$500,000**

☐ **Check here if group would like the Optional Add-On plan (if this option is desired, enter the monthly Optional Add-On rate in Section 1)**

3. Optional coverages
(If applicable)

Chaperone rider enter .10 here _____

Adventure Sports rider enter .20 here +_____

(B) Total rider premium factor = _____ **(B) Enter this amount to the right of the 1. in section 4**

4. Premium calculation

_____ **x 1.** _____
(A) Amount from section 2 (A) **(B)** Enter the amount from section 3 (B)

=_____ +_____ =_____
Total premium **$20 express mail** *if requested* **TOTAL AMOUNT DUE**

IMG PRODUCER USE ONLY

Producer#: 533681
Name: CUB INTERNATIONAL LTD
Address: 71-75 shelton street - covent garden
City, State, Zip:
Phone: 00442034684981
Email: admin@cubinternational.com

Note: *If participants within the group would like to designate a beneficiary, please use the Beneficiary Designation form.*

Sponsor or organization: _____

Mailing address:_____

City/State/Zip:_____

Phone:_____Fax:_____

Government issued ID number:_____

Authorized representative name:_____

Send Confirmation of Coverage and communications to the following email:

_____

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

☐ **Mail option:** *I do not mind the delays associated with receiving the initial communication via regular mail and prefer to also receive a paper copy of the coverage verification letter and insurance contract*

Requested effective date:_____

Earliest date of departure:_____

Requested expiration date:_____

Purpose of trip & program: _____

Destinations:_____

Payment method: ☐ Check (To IMG) ☐ Wire ☐ Money Order (To IMG) ☐ JCB
☐ MasterCard ☐ Visa ☐ American Express ☐ Discover
eCheck (ACH) available online upon request

By supplying my account information, Sponsor wishes 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, Sponsor represents and warrants that it 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, Sponsor agrees to pay via my credit card or applicable account the premium amount owed and has read and agrees 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's phone & email: _____

Cardholder's billing address: _____

_____

1. Subscription. The Sponsor or Organization (also a "Sponsor") represents and warrants it is the authorized agent of the participants and hereby applies and subscribes, for and on behalf of participants listed on the Application Form, to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for the Patriot Group Exchange Program as underwritten and offered by Sirius International Insurance Corporation (publ) (the Company) on the date of its receipt hereof, and as administered by the Company's authorized agent and plan administrator, International Medical Group, Inc. (IMG). The Sponsor on behalf of itself and the participants understands and agrees: **(i)** the insurance applied for is not general health insurance, but is intended for the participants' use in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, **(ii)** coverage is not renewable, **(iii)** the Sponsor must pay premiums for the entire period of coverage applied for, and no coverage will be effective until this application has been accepted in writing by the Company or by IMG on its behalf, **(iv)** 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 **(v)** by submission of this application and/or any future claim for benefits, the Sponsor on behalf of itself and the participants purposefully initiates and takes 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(s) 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 the Sponsor on behalf of itself and the participants hereby expressly consents. Indiana surplus lines law shall govern all rights and claims raised under the Certificate of Insurance.

2. Acknowledgment. The Sponsor on behalf of itself and the participants understands and agrees that: **(i)** the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of the applicants, (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 three years 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 the insurance, (iii) the subjects of insurance applied for are not intended or considered by the Sponsor, the participants, the Company or IMG to be resident, located, or 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.

3. Authorization for Release of Information. The Sponsor on behalf of each participant authorizes 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 the participant or on the participant's behalf, has any records or knowledge of the participant's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the participant, and any non-medical information about the participant, to disclose the participant's entire medical record, file, history, medications, and any other information concerning the participant and to give any and all such information to the participant's agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

4. Certification. The Sponsor on behalf of itself and the participants hereby certifies, represents and warrants that they have read the foregoing statements and any marketing materials and sample insurance contract which were made available upon request and prior to the application , and they understand the foregoing statements, and that each participant listed: (i) is eligible to participate in the insurance program applied for, and (ii) is currently in good health and has not been diagnosed with, sought consultation or been treated for, and has not experienced manifestation or symptoms of and does not suffer from any pre-existing or other medical condition which he/she foresees may require treatment during this insurance or for which he/she intends to claim under this insurance. As the legal representative of the Sponsor and each participant, the undersigned warrants his/her authority and capacity to so act and to bind the Sponsor and such participants. By acceptance of coverage and/or submission of any claim for benefits, each participants ratifies and affirms the authority of the signer and Sponsor to so act and bind the participant.

5. The Sponsor represents and warrants that under the insurance offered to the participants, participation in the program is completely voluntary; the sole functions of the Sponsor with respect to the insurance is, without endorsing the program, to permit the insurer to publicize the program to participants, to collect premiums and to remit them to the insurer; and the Sponsor receives no consideration in the form of cash or otherwise in connection with the insurance. The Sponsor acknowledges it must and agrees it will disclose certain material, including reports, statements, notices, and other documents, to participants, beneficiaries and other specified individuals including but not limited to furnishing certain material to all participants covered under the insurance contract and beneficiaries receiving benefits under the insurance contract at stated times or if certain events occur; furnishing certain material to participants and beneficiaries upon their request; and making certain material available to participants and beneficiaries for inspection at reasonable times and places. The Sponsor represents and warrants it will use measures reasonably calculated to ensure actual, prompt receipt of the material by participants, beneficiaries and other specified individuals.

6. Patient Protection and Affordable Care Act (PPACA) Sponsor has informed all participants that they, and any accompanying spouse and dependent(s), also may be subject to the requirements of the Affordable Care Act. The Sponsor on behalf of itself and the participants 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 (*international students on F, J, M and Q visas, and certain family members of students, are not subject to the individual mandate for their first 5 years in the U.S. All other J categories - teacher, trainee, work and travel, au pair, high school, etc. - are not subject to the individual mandate for 2 years out of the past six*), (iii) penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so, and (iv) 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 and the Company and IMG shall have no liability whatsoever, including for any penalties that you may incur, for your failure to obtain required PPACA compliant coverage.

The Sponsor hereby arranges for insurance to be offered to the participants, the participants have voluntarily authorized this action in writing, and the participants were also given the opportunity to make other arrangements to obtain insurance. These authorizations are kept on file by the Sponsor and will be made available to the Company upon request.

7. The Sponsor on behalf of itself and the participants hereby certifies, represents, and warrants that they have read, or have had read to them, all statements on this application. The Sponsor on behalf of itself and the participants represents 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. The Sponsor on behalf of itself and the participants understands and agrees that subject to 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. The Sponsor on behalf of itself and the participants understands that if premium is returned unpaid for any reason, coverage becomes null and void. The Sponsor on behalf of itself and the participants acknowledges and understands 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. The Sponsor on behalf of itself and the participants wishes to receive information and communicate electronically, and prefers to use email rather than regular mail. The Sponsor on behalf of itself and the participants agrees IMG may provide the recipient with any communications in electronic format, and IMG is not required to send paper communications, unless and until the participant withdraws this consent. The Sponsor on behalf of itself and the participants also agrees it is the participant's responsibility to provide IMG with true, accurate and complete email address, contact, and other information related to the coverage, and to maintain and promptly update any changes in this information.

_____ _____

Signature of Authorized Representative Date