Patriot Exchange Program - Individual Application

1. Complete all sections and sign the application. *(Please print)*
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

Primary applicant's name: Mr. / Mrs. / Ms. **Last:** _____ **First:** _____ **Middle:** _____
Mailing address: _____
Country of citizenship: _____ **Country of residence:** _____
Destination country: _____ **Phone:** _____
☐ Male ☐ Female

Are you participating in a Work & Travel program? ☐ Yes ☐ No If yes, Program Name: _____

Is the applicant a J2 visa holder? ☐ Yes ☐ No
(if Yes, applicant is only eligible to apply if the J1 visa holder is insured under a plan through his or her education or cultural program.)

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

☐ **Regular 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 to the mailing address listed.

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: _____ Government issued ID number: _____

Beneficiary:
Name: First: _____ Last: _____
Relationship: _____

1. Select the area of coverage

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

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

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

☐ **Check here if you would like the optional Add-On plan**

3. Names of individuals applying for coverage:

Insured name(s)	Date of birth	Monthly premium rate/ premium with Optional Add-On plan
Primary applicant:		
Spouse:		
Child:		
Child:		
	Subtotal A	

4. Premium calculation

Subtotal A		
# of months	x	
Estimated monthly premium	=	
Adventure Sports rider (multiply by 1.20 if requested)	x	
Estimated premium	=	
Express mail (add $20 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

Payment method: ☐ Check (To IMG) ☐ Money Order (To IMG) ☐ Wire

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover ☐ JCB

eCheck (ACH) available online or upon request

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: _____

_____

1. 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 Patriot Exchange Program 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.

2. Acknowledgment 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 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 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.

3. 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.

4. 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.

5. 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 (*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.

6. 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 (we) 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 (we) wish to receive information and communicate electronically, and prefer to use my (our) email address rather than regular mail. I (we) agree IMG may provide me (us) with any communications in electronic format, and IMG is not required to send paper communications to me (us), unless and until I (we) withdraw this consent. I (we) also agree it is my (our) responsibility to provide IMG with true, accurate and complete email address, contact, and other information related to my (our) coverage, and to maintain and promptly update any changes in this information.

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

_____

Date: _____