Patriot Platinum

Travel Medical Insurance℠

First-class travel medical insurance for individuals, families and groups of five or more

WWW.IMGLOBAL.COM

IMG™

WHY IMG?

International Medical Group® (IMG®), an award-winning provider of global insurance benefits and assistance services for more than 25 years, enables its members to worry less and experience more by delivering the protection they need, backed by the support they deserve. IMG offers a full line of international medical insurance products, as well as trip cancellation programs, stop loss insurance, medical management services and 24/7 emergency medical and travel assistance — all designed to provide members Global Peace of Mind® while they're away from home.

Global Support. With offices and partners across the globe, IMG provides the support you need, when you need it. In fact, it's our corporate mission to be there to protect and enhance your health and well-being.

Service Without Obstacles. IMG's team of international, multilingual specialists is accustomed to working in multiple time zones, languages and currencies. Our global reach means we can work without barriers.

International Provider Access℠ (IPA). In addition to our expansive PPO network available for treatment received within the U.S., our proprietary IPA network of more than 17,000 accomplished physicians and facilities allows you to access quality care worldwide. Our direct billing arrangements can also ease the time and upfront expense at select providers.

Financial Stability. Our globally recognized underwriters, A-rated Sirius International Insurance Corporation (publ) and certain underwriters at Lloyd's, offer the financial security and reputation demanded by international consumers.

Accessible Technology. Log on to the secure, 24-hour online portal, MyIMG℠, to submit and view your claims, manage your account, search for providers, Live Chat with representatives and more.

International Emergency Care. When you're away from home and a medical emergency occurs, you may not be able to wait for regular business hours. With our on-site medical staff, you have 24-hour access to highly qualified coordinators of emergency medical services and international treatment.

WHY CHOOSE PATRIOT PLATINUM

Most people assume they will be covered by their standard health insurance when they travel internationally, but that isn't always the case. Without even realizing it, you may be putting your health at risk. Don't let your medical coverage be an uncertainty. Travel with IMG's Patriot Platinum Travel Medical Insurance℠ so you can spend more time enjoying your international experience and less time worrying about your medical coverage.

Patriot Platinum is designed for individuals, families, and groups of five or more who desire first-rate protection when traveling internationally. The plan is available for U.S. and non-U.S. citizens for a minimum of 10 days up to three years. With a Patriot Platinum plan, you'll also have exclusive access to enhanced benefits and services.

WORLD-CLASS SERVICES

My*IMG*℠

MyIMG is our online member portal that allows you to easily access and manage your insurance information. Key features include:

- Manage your claims
- Initiate precertification
- Locate a provider
- Obtain plan documents
- Request ID cards
- Recommend a provider/facility

Global Concierge & Assistance Services℠

Patriot Platinum provides clients more than insurance protection. IMG's Global Concierge and Assistance Services offers the knowledge and information needed to keep you healthy and safe. Below is a list of services handled by a dedicated service team that is available 24 hours a day, seven days a week, exclusively for our Platinum members.

- Dedicated Service Line & Claims Team
- Bag Tracking
- Embassy & Consulate Referrals
- Emergency Cash Transfers
- Security Updates & Country Profiles
- Lost Passport/Travel Documents Assistance
- Prescription Drug Replacement Assistance
- Emergency Travel Arrangements
- Legal Referrals
- Drug Translation Services
- Pre-Trip Health & Safety Advisories
- Emergency Message Relay

eDocAmerica

As a registered user of IMG's online member portal, MyIMG, you can access eDocAmerica, which allows you to consult with board-certified physicians, licensed psychologists, pharmacists, dentists, dieticians and fitness trainers to assist you with any routine health-related questions you have.

Universal Rx Pharmacy Discount Savings

This discount savings program allows you to purchase prescriptions at one of over 35,000 participating pharmacies in the U.S. and receive the lower of 1) Universal Rx contract price or 2) the pharmacy regular retail price. This program is not insurance coverage; it is purely a discount program.

PLAN INFORMATION & HIGHLIGHTS

Maximum Limits	$1,000,000 / $5,000,000 / $8,000,000
Individual Deductible	$0 / $100 / $250, $500 / $1,000 / $2,500 / $5,000 / $10,000 / $25,000
Family Deductible	Three times the individual deductible
Coinsurance - Treatment Received Outside of the U.S. & Canada	No coinsurance
Coinsurance - Treatment Received Within the U.S. & Canada	**In the PPO Network** - No coinsurance **Out of the PPO Network** - The plan pays 90% of eligible medical expenses up to $5,000, then 100% up to the maximum limits
Benefit Period	12 months
Global Concierge & Assistance Services	Exclusive access to additional emergency travel assistance services handled by dedicated team
eDocAmerica	Access to board-certified physicians, licensed psychologists, pharmacists, dentists, dieticians and fitness trainers to assist with any routine health-related questions
International Emergency Care	A wide range of international emergency benefits available, including emergency evacuation, emergency reunion, return of mortal remains, return of minor children and more

SCHEDULE OF BENEFITS *(All coverages, benefits and premium amounts shown are in U.S. dollars.)*

MEDICAL BENEFITS *Usual, reasonable and customary charges. Subject to deductible and coinsurance when applicable.*

Hospital Room and Board	Up to the maximum limit
Intensive Care	Up to the maximum limit
Medical Expenses	Up to the maximum limit
Out-patient Medical Expenses	Up to the maximum limit
Local Ambulance	Up to the maximum limit
Emergency Room Accident	Up to the maximum limit
Emergency Room Illness with Inpatient Admission	Up to the maximum limit
Emergency Room Illness without Inpatient Admission	Up to the maximum limit with additional $250 deductible
Dental - Injury Due to Accident	Up to the maximum limit
Dental - Sudden Dental Emergency	Up to $250
Hospital Daily Indemnity	Up to $250 per night for a maximum of 10 days
Supplemental Accident	Up to $300

INTERNATIONAL EMERGENCY CARE *When coordinated through the plan administrator.*

Emergency Medical Evacuation	Up to the maximum limit
Emergency Reunion	Up to $100,000
Return of Mortal Remains or Cremation/Burial	Up to $100,000 for return of mortal remains; $5,000 for cremation/burial
Return of Minor Children	Up to $100,000
Political Evacuation	Up to $100,000
Natural Disaster	$250 per day for five days
Remote Transportation	$5,000 per period of coverage $20,000 lifetime maximum
Identity Theft Assistance	Up to $500 per Period of Coverage
Lost/Stolen Luggage, Valuables, Personal Papers	Up to $500
Felonious Assault	Up to $10,000

ADDITIONAL BENEFITS

Terrorism	Up to the maximum limit
Sports & Activities Coverage	Up to the maximum limit for basic sports
Sudden and Unexpected Recurrence of a Pre-Existing Condition - Medical *(for U.S. citizens only)*	**Up to age 65 with primary health plan:** URC up to plan maximum. **Up to age 65 without primary health plan:** $20,000 lifetime maximum. **Age 65+:** $2,500 lifetime maximum
Sudden and Unexpected Recurrence of a Pre-existing Condition - Medical *(for non-U.S. citizens only)*	**Up to age 65:** $50,000 lifetime maximum for eligible medical expenses **Age 65+:** $2,500 lifetime maximum
Sudden and Unexpected Recurrence of a Pre-existing Condition - Emergency Medical Evacuation	Up to $25,000 of eligible costs and expenses
Incidental Home Country Coverage	Up to a cumulative two weeks
End-of-Trip Home Country Coverage	One month for every four months of travel coverage; up to a maximum of three months (Individual plan only)
Trip Interruption	Up to $10,000
Common Carrier Accidental Death	$100,000 per adult; $25,000 per child; maximum of $250,000 per family
Accidental Death & Dismemberment	$50,000 principal sum
Small Pet Common Air Carrier Accidental Death	Up to $500

PLAN RATES - INDIVIDUAL

PATRIOT PLATINUM INTERNATIONAL *(U.S. citizens)*

MONTHLY RATES

Age	Option 1 $1,000,000	Option 2 $5,000,000	Option 3 $8,000,000
18-29	$80	$94	$100
30-39	$105	$123	$131
40-49	$135	$158	$169
50-59	$226	$264	$283
60-64	$298	$349	$373
65-69	$313	$366	$391
70-79*	$321	NA	NA
80+**	$465	NA	NA
Dependent Child	$72	$85	$90
Individual Child	$77	$90	$96

DAILY RATES
(10-day minimum)

Age	Option 1 $1,000,000	Option 2 $5,000,000	Option 3 $8,000,000
18-29	$2.70	$3.15	$3.35
30-39	$3.50	$4.10	$4.40
40-49	$4.50	$5.30	$5.65
50-59	$7.55	$8.80	$9.45
60-64	$9.95	$11.65	$12.45
65-69	$10.45	$12.20	$13.05
70-79*	$10.70	NA	NA
80+**	$15.50	NA	NA
Dependent Child	$2.40	$2.85	$3.00
Individual Child	$2.60	$3.00	$3.20

PATRIOT PLATINUM AMERICA *(Non-U.S. citizens)*

MONTHLY RATES

Age	Option 4 $1,000,000	Option5 $5,000,000	Option 6 $8,000,000
18-29	$115	$134	$144
30-39	$151	$177	$188
40-49	$234	$274	$292
50-59	$347	$405	$434
60-64	$412	$481	$515
65-69	$433	$505	$540
70-79*	$444	NA	NA
80+**	$644	NA	NA
Dependent Child	$101	$117	$126
Individual Child	$104	$122	$131

DAILY RATES
(10-day minimum)

Age	Option 4 $1,000,000	Option 5 $5,000,000	Option 6 $8,000,000
18-29	$3.85	$4.50	$4.80
30-39	$5.05	$5.90	$6.30
40-49	$7.80	$9.15	$9.75
50-59	$11.60	$13.50	$14.50
60-64	$13.75	$16.05	$17.20
65-69	$14.45	$16.85	$18.00
70-79*	$14.80	NA	NA
80+**	$21.50	NA	NA
Dependent Child	$3.40	$3.90	$4.20
Individual Child	$3.50	$4.10	$4.40

PLAN RATES - GROUP

PATRIOT PLATINUM INTERNATIONAL *(U.S. citizens)*

MONTHLY RATES

Age	Option 1 $1,000,000	Option 2 $5,000,000	Option 3 $8,000,000
18-29	$72	$85	$90
30-39	$95	$111	$118
40-49	$122	$142	$152
50-59	$203	$238	$255
60-64	$268	$314	$336
65-69	$282	$329	$352
70-79*	$289	NA	NA
80+**	$419	NA	NA
Dependent Child	$65	$77	$81
Individual Child	$69	$81	$86

DAILY RATES
(10-day minimum)

Age	Option 1 $1,000,000	Option 2 $5,000,000	Option 3 $8,000,000
18-29	$2.40	$2.85	$3.00
30-39	$3.20	$3.70	$3.95
40-49	$4.10	$4.75	$5.10
50-59	$6.80	$7.95	$8.50
60-64	$8.95	$10.50	$11.20
65-69	$9.40	$11.00	$11.75
70-79*	$9.65	NA	NA
80+**	$14.00	NA	NA
Dependent Child	$2.20	$2.60	$2.70
Individual Child	$2.30	$2.70	$2.90

PATRIOT PLATINUM AMERICA *(Non-U.S. citizens)*

MONTHLY RATES

Age	Option 4 $1,000,000	Option5 $5,000,000	Option 6 $8,000,000
18-29	$104	$121	$130
30-39	$136	$159	$169
40-49	$211	$247	$263
50-59	$312	$365	$391
60-64	$371	$433	$464
65-69	$390	$455	$486
70-79*	$400	NA	NA
80+**	$580	NA	NA
Dependent Child	$91	$105	$113
Individual Child	$94	$110	$118

DAILY RATES
(10-day minimum)

Age	Option 4 $1,000,000	Option 5 $5,000,000	Option 6 $8,000,000
18-29	$3.50	$4.05	$4.35
30-39	$4.55	$5.30	$5.65
40-49	$7.05	$8.25	$8.80
50-59	$10.40	$12.20	$13.05
60-64	$12.40	$14.45	$15.50
65-69	$13.00	$15.20	$16.20
70-79*	$13.35	NA	NA
80+**	$19.35	NA	NA
Dependent Child	$3.05	$3.50	$3.80
Individual Child	$3.15	$3.70	$3.95

**Ages 70-79 $100,000 maximum*
***Ages 80+ $20,000 maximum*

Rates are based on a $250 deductible option. For other deductible options, please see the application.
IMG reserves the right to issue the most current rates in the event these expire, are modified or replaced with a newer version. Rates include surplus lines tax where applicable.

PLAN RIDERS & RATES

OPTIONAL RIDERS *With the exception of the enhanced AD&D Rider, optional riders apply to all individuals listed on the application form.*

Adventure Sports Rider *(available to insureds up to age 65)*	**Age** 0-49 50-59 60-64	**Lifetime Maximum** $50,000 $30,000 $15,000
Enhanced AD&D Rider* *(available to insureds up to age 65)*	Up to an additional $400,000	
Citizenship Return Rider	Up to the maximum limit	
Personal Liability Injury to third party Damage to third-party property	 $2,000 limit after $100 deductible $500 limit after $100 deductible	
Evacuation Plus Rider* (available to insureds up to age 65)	Up to age 65. Non Life-threatening Medical Evacuation: Up to a maximum of $50,000; Natural Disaster Evacuation: Up to a maximum of $10,000	
Chaperone/Faculty Leader Replacement Rider**	Up to $3,000 for round-trip economy airline ticket	

Rider option is available on individual plans only.
****Rider option is available on group plans only.***

ENHANCED AD&D RIDER MONTHLY RATES*

Up to $100,000 additional coverage	$8
Up to $200,000 additional coverage	$16
Up to $300,000 additional coverage	$24
Up to $400,000 additional coverage	$32

**Available to the primary insured only. Available with a minimum purchase of three months of medical and AD&D rider coverage. Premium is charged in whole-month increments.*

EVACUATION PLUS RIDER MONTHLY RATE**

Premium per covered insured per month	$70

***Must be purchased for a minimum of three months regardless of the minimum number of days being traveled. Premium is charged in whole-month increments.*

CONDITIONS OF COVERAGE

1. Coverage and benefits are subject to the deductible and coinsurance, and all terms of the Certificate of Insurance and Master Policy.
2. Coverage under a Patriot Platinum plan is secondary to any other coverage.
3. Coverage and benefits are for medically necessary, usual, reasonable and customary charges only.
4. Charges must be administered or ordered by a physician.
5. Charges must be incurred during the period of coverage or the benefit period.
6. Claims must be presented to IMG for payment within 90 days from the date the claim was incurred.

ELIGIBILITY

The following conditions apply to all persons applying for and/or enrolling in a Patriot Platinum individual or group plan.

- Patriot Platinum is travel medical insurance for U.S. citizens traveling outside of the United States with coverage for brief returns to the U.S., and for non-U.S. citizens traveling outside of their home country.

- For those under 65 years of age and visiting the U.S., your initial period of coverage must begin within six months of arrival in the U.S. For those 65 years of age and older, it must begin within 30 days of arrival. These requirements will be waived with proof of previous valid international travel insurance. Prior U.S. domestic health care coverage does not meet this eligibility requirement. Please provide the name of your international insurance carrier on the application form. If you are not in the U.S. at the time of application, please indicate your expected date of arrival on your application form.

ENROLLMENT

To apply, simply complete and return the application. If approved, you will receive a fulfillment kit, which includes an identification card, declaration of insurance and a Certificate Wording containing a complete description of benefits, exclusions and terms of the plan.

RENEWAL OF COVERAGE

Subject to the terms of the plan, Patriot Platinum Travel Medical Insurance can be extended for a minimum of five days up to a 365-day period, until reaching a maximum of 24 continuous months. Prior to the end of each period of coverage purchased, you will receive renewal information. You have the option to renew online or you may complete a paper renewal form. Each insured person must only satisfy one deductible and coinsurance within each 12-month coverage period. Please note: Renewal rates may differ from initial rates. *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 the Patient Protection and Affordable Care Act (PPACA).*

QUALITY GUARANTEE

Your satisfaction is very important to IMG. If you are not pleased with this product for any reason, you may submit a written request, prior to your effective date, for cancellation and refund of your premium. If you do not have any claims filed with IMG, you may cancel your plan after your effective date; however, the following conditions will apply:

1. You will be required to pay a $50 cancellation fee, and only full-month premiums will be considered for refunds.
2. For example, if you choose to cancel your coverage two months and two weeks prior to the date your coverage ends, IMG will only consider the two full months for a refund. If you have filed claims, your premium is non-refundable.

IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA):
This insurance is not subject to and does not provide benefits required by PPACA. As of January 1, 2014, PPACA requires 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 the insurance requirements applicable to them, and the company and IMG shall have no liability whatsoever, including for any penalties a person may incur, for failure to obtain coverage required by any applicable law including, without limitation, PPACA.


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Producer Contact Information

Travel Insurance Center
8420 W Dodge Rd
5th Floor
Omaha, NE 68114
Phone: 402-343-3699
Fax: 402-343-9959
info@travelinsurancecenter.com
http://www.travelinsurancecenter.com

TM

This invitation to inquire allows eligible applicants an opportunity to seek information about the insurance offered, and is limited to a brief description of any loss for which benefits may be payable. Benefits are offered as described in the insurance contract. Benefits are subject to all deductibles, coinsurance, provisions, terms, conditions, limitations and exclusions in the insurance contract. Certain contracts do contain a pre-existing condition exclusion and do not cover losses or expenses related to a pre-existing condition.

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Version 0117

PATRIOT PLATINUM[SM] INDIVIDUAL APPLICATION

Please print legibly and complete ALL SECTIONS *(front and back)* of this application

1 PRIMARY APPLICANT INFORMATION

☐ Male ☐ Female	First Name:	Last Name:	Middle:
Government Issued ID Number:		Country of Citizenship:	
Country of Residence:	Home Country:	Destination Country(ies):	

2 FULFILLMENT AND INFORMATION DELIVERY METHOD

☐ **Communications should be sent via email to:**

☐ **For mail fulfillment kit, and renewal information** *(if applicable):* **I do not mind the delays associated with receiving the initial communication via regular mail. I prefer to receive a paper copy of the coverage verification letter and insurance contract to the following address:**

Name:		Address:
City:	Postal Code:	Country:

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

3 PLAN OPTION AND ADDITIONAL COVERAGE OPTIONS

Select the coverage plan and maximum limit. Check one plan and one option:

☐ Patriot Platinum America for non-U.S. citizens: ☐ $1 Million ☐ $5 Million ☐ $8 Million

☐ Patriot Platinum International for U.S. citizens: ☐ $1 Million ☐ $5 Million ☐ $8 Million

Select additional coverage option *(optional)*:

☐ Citizenship Return Rider:

If you are a U.S. citizen and elect this rider, have you resided outside of the U.S. continuously for the past 6 months? ☐Yes ☐No

Do you have a current health plan in force? ☐Yes ☐No ***If you answered No to either question, you are ineligible for this rider.***

Requested Effective Date: ___/___/___ *(month/day/year)*	Date of departure from your Home Country: ___/___/___ *(month/day/year)*
	Date of return to your Home Country: ___/___/___ *(month/day/year)*

Are you a non-U.S. citizen replacing current international coverage? ☐Yes ☐No

Current carrier:	Date of arrival in the U.S.:	Expiration date of current coverage:

4 PREMIUM CALCULATION

Names of Persons to be insured: *Please attach additional sheet for more children*		Date of Birth *(month/day/year)*	Monthly Rate	# of Months Travel Coverage	Total	Daily Rate	# of Days	Total
Applicant		___/___/___	_____ x _____ =			_____ x _____ =		
Spouse		___/___/___	_____ x _____ =			_____ x _____ =		
Child 1		___/___/___	_____ x _____ =			_____ x _____ =		
Child 2		___/___/___	_____ x _____ =			_____ x _____ =		
		TOTAL	**(A)** _____		**(B)** _____			**(C)** _____

5 DEDUCTIBLE OPTION

CIRCLE ONE: Select one deductible by circling it, then enter the applicable rate factor amount in the premium calculation box in Section 7 **(D)**

Deductible	$0	$100	$250	$500	$1000	$2500	$5000	$10,000	$25,000
Rate Factor	1.25	1.10	1.00	.90	.80	.70	.60	.55	.45

6 END OF TRIP HOME COUNTRY COVERAGE *(optional)*

One month for every four months of consecutive coverage up to a maximum of three months of End of Trip Home Country Coverage

This will be added as additional months of coverage to your planned travel period and will begin upon the date of return to your home country

Monthly Rate Total (A)	# of Months Home Country Coverage	Total Home Country Coverage Premium
_____	X _____	= _____
Total		**(E)** _____

Beneficiaries

If applicants would like to designate a beneficiary, the beneficiary designation form can be accessed via myimg.imglobal.com

APPLICATION FORM CONTINUED ON BACK

PATRIOT PLATINUM℠ INDIVIDUAL APPLICATION

Please print legibly and complete ALL SECTIONS *(front and back)* of this application

7 PLAN PREMIUM

BASE PLAN

(B) Monthly premium total *(from B in Section 4)*	
(C) Daily premium total *(from C in Section 4)*	
(E) End of Trip Home Country Coverage premium total *(from E in Section 6)*	
B + C + E =	
(D) Deductible rate factor *(see Section 5)*	x
(F) Base premium	

ADDITIONAL COVERAGE OPTIONS

Adventure Sports Rider *(enter .20 if applicable)*	
Citizenship Return Rider *(enter .05 if applicable)*	+
Personal Liability Rider *(enter .10 if applicable)*	+
(G) Total Rider Factor	=

Enhanced AD&D Rider

(To purchase, please complete the following calculation)

_____ x _____ = _____

# of months | Rate | **(H)**

Evacuation Plus Rider

(To purchase, please complete the following calculation)

_____ x _____ x $70.00 = _____

# of months | # of Insureds | **(I)**

TOTAL PREMIUM

Enter the amount from **(F)**	
Enter the amount from **(G)** to the right of the **1.**	x **1.** =
Enter the amount from **(H)**	+
Enter the amount from **(I)**	+
Optional express mail $20	+
TOTAL AMOUNT DUE	=

IMG PRODUCER USE ONLY

Producer #:	16927
Name:	Travel Insurance Center
Address:	8420 W Dodge Rd - 5th Floor
City: Omaha	State: NE Zip: 68114
Phone:	402-343-3699
Email:	info@travelinsurancecenter.com

8 SUBSCRIPTION

The undersigned on behalf of the above individuals (applicants) hereby apply and subscribe to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for the insurance coverage requested above and 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). The applicants understand and agree: (i) the insurance applied for is not an employee welfare benefit plan, accident & health product, health insurance, major medical, nor a health plan subject to or complying with U.S. laws, but is intended for use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) The applicants must pay premiums for the entire period of coverage in advance, and no coverage will be effective until the required premium has been paid and 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) the Company relies on the accuracy, truthfulness, and completeness of the information provided herein and any misrepresentation or omission contained herein will void the insurance contract 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. The applicants 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, 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 the insurance will be in Marion County, Indiana, for which the applicants hereby consent. The applicants consent and agree that Indiana surplus lines law shall govern all rights and claims raised under the insurance contract. **ACKNOWLEDGEMENT**. The applicants understand and agree that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of applicants and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) the 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 time frame outlined in the contract prior to the effective date, 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 applicants, the Company or IMG to be resident, located, or expressly to be performed in any particular jurisdiction, 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 and IMG has no direct or independent liability under any insurance contract. **AUTHORIZATION FOR RELEASE OF INFORMATION**. The applicants 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 them or on their behalf, has any records or knowledge of their health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of them, and any non-medical information about me, to disclose their entire medical record, file, history, medications, and any other information concerning them and to give any and all such information to their agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries. **CERTIFICATION**. The applicants hereby certify, represent and warrant that : (i) 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 or that they have been read to them, and the applicants understand them, (ii) they are eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) they 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 the applicants foresee may require treatment during the insurance or for which the applicants intend to claim under the insurance, and (iv) each applicant is not hospitalized, disabled, or HIV+. If signed as the legal representative of the applicant, the signer warrants their authority and capacity to so act and to bind each applicant. By acceptance of coverage and/or submission of any claim for benefits, each applicant ratifies the authority of the signer to so act and bind the applicants. **IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)**: This insurance is not subject to, and does not provide benefits required by, PPACA. 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. Penalties may be imposed on persons 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 the applicants' responsibility to determine the insurance requirements applicable to them and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the applicants may incur, for their failure to obtain coverage required by any applicable law including without limitation PPACA. **E-CONSENT**. The applicants wish to receive information and communicate electronically, and prefer to use an e-mail address rather than regular mail. The applicants agree IMG, its affiliates, and subsidiaries may provide each insured person with any communications in electronic format, and paper communications are not required, unless and until the applicant withdraws this consent. The applicants unambiguously give consent to the transfer of personal data to entities established in a country outside the EU Member States. This consent is freely given, specific for the administration of coverage and benefits, and an informed indication of the applicants' wishes. The applicants acknowledge and understand the transfer is necessary for the performance of a contract, taken in response to their request, and necessary for the conclusion or performance of a contract concluded in their interest. The applicants also agree it is their 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. 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.

Signature of Insured or Proxy *(Required)*	**X** _____
Date: ___/___/___ *(month/day/year)*	Phone:

9 PAYMENT METHOD

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ Wire ☐ Check (To IMG) ☐ Money Order (To IMG) *eCheck (ACH) (available 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.

Card #:	Expiration Date: ___/___/___ *(month/day/year)*	Cardholder Name:
Signature: (Required)	Cardholder Daytime Phone:	Email:
Cardholder Billing Address:		

Payment must be made for the total number of months you want coverage. All payments must be made in U.S. dollars and drawn on U.S. banks.

PATRIOT PLATINUM GROUP℠ APPLICATION

To Enroll

1. Complete all sections and sign application (front and back - please print)
2. Please make check or money order payable to IMG and enclose in envelope with signed application form
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	Group Member's Name		Date of Birth *(month/day/year)*	Government Issued ID Number	Group Member's Requested Effective Date *(month/day/year)*	Group Member's Requested Expiration Date *(month/day/year)*	Group Member's Requested Departure Date If Different Than Group *(month/day/year)*	Monthly Rate	Daily Rate
	Country of Citizenship	Home Country							
☐1									
☐2									
☐3									
☐4									
☐5									

Please check the box in front of the applicant's name to identify the Chaperone/Faculty Leader ***(if the Chaperone Rider is selected)*** **Subtotal** **A**_____ **B**_____
(attach additional sheets, if necessary)

2 Premium

_____ x _____ = _____
Subtotal **A** *(from Subtotal* **A** *above)* *# of Months* *Total* **A**

_____ x _____ = _____
Subtotal **B** *(from Subtotal* **B** *above)* *# of Days* *Total* **B**

To pay in monthly installments (please first calculate your total premium in section 6 of the application)

_____ ÷ _____ = _____ + $10.00 = $_____ *(Minimum initial payment required)*
Total Premium Number of months Billing fee Periodic payment

3 Select the coverage plan and plan options *(Check one plan and one option)*

☐ **Patriot Platinum America Group for non-U.S. citizens:**

☐ $1 Million ☐ $5 Million ☐ $8 Million

☐ **Patriot Platinum International Group for U.S. citizens:**

☐ $1 Million ☐ $5 Million ☐ $8 Million

☐ **Non-U.S. citizens if replacing current international coverage**
Current carrier _____ Date of arrival in the U.S. ___/___/___ *(month/day/year)*
OR Expiration date of current coverage ___/___/___ *(month/day/year)*

4 Deductible Option

CIRCLE ONE:
Select one deductible by circling it, then enter the applicable rate factor amount in the premium calculation box in Section 6

Deductible	$0	$100	$250	$500	$1,000	$2,500	$5,000	$10,000	$25,000
Rate Factor	1.25	1.10	1.00	.90	.80	.70	.60	.55	.45

5 End of Trip Home Country Coverage

One month for every four months of purchased Travel Medical coverage up to a maximum of three months of Home Country Coverage. This will be added as additional months of coverage to your planned travel period and will begin upon the date of return to your home country

This will be added as additional months of coverage to your planned travel period and will begin upon the date of return to your home country

Total **C**

_____ x _____ = _____
Monthly Rate Subtotal (A) # of months Home Country Coverage Total Home Country Coverage Premium

Beneficiaries:
If applicants would like to designate a beneficiary, the beneficiary designation form can be accessed via myimg.imglobal.com

6 Plan Premium

BASE PLAN

(A) Monthly premium total *(from Total A in Section 2)*	_____
(B) Daily premium total *(from Total B in Section 2)*	+_____
(C) End of Trip Home Country Coverage premium total *(from Total C in Section 5)*	+_____
A + B + C =	=_____
Deductible rate factor *(see Section 4)*	x_____
(D) Base Premium	=_____

ADDITIONAL COVERAGE OPTIONS

Adventure Sports Rider
(enter .20 if applicable) _____

Chaperone Rider
(enter .10 if applicable) +_____

Citizenship Return Rider
(enter .05 if applicable) +_____

If you are U.S. citizen and elect this rider:
Have you resided outside of the U.S. continuously for the past 6 months? ☐ Yes ☐ No
Do you have a current health plan in force? ☐ Yes ☐ No
If you answered No to either questions, you are ineligible for this rider.

Personal Liability Rider
(enter .10 if applicable) +_____

(E) Total Rider Factor(s) =_____

TOTAL PREMIUM

Enter the amount from **(D)**	_____
Enter the amount from **(E)** to the right of **1.**	x 1._____ =_____
$20 optional express mail	+_____
TOTAL AMOUNT DUE	=_____

PATRIOT PLATINUM GROUP℠ APPLICATION

7 Sponsoring Organization:

Mailing Address:	City:	State:	Postal Code:
Responsible Officer Contact Name:		Government Issued ID Number:	
Send confirmation of coverage and communications to the following email:			Phone Number:

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

If the address provided is in Florida, is the applicant currently located in Florida? ☐ Yes ☐ No *(Determines applicable surplus lines tax and will not affect coverage)*	Group Name:
Requested Effective Date: ___/___/___ *(month/day/year)*	Earliest Date of Departure: ___/___/___ *(month/day/year)* Requested Expiration Date: ___/___/___ *(month/day/year)*
Purpose of Trip & Program:	Destinations:

8 Payment Method:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ JBC ☐ Wire ☐ Check (To IMG) ☐ Money Order (To IMG) *eCheck (ACH) (available 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 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: ___/___/___ *(month/day/year)*	Cardholder Name:
Signature: *(Required)*	Cardholder Daytime Phone:	Email:
Cardholder Billing Address:		

Payment must be made for the total number of months you want coverage. All payments must be made in U.S. dollars and drawn on U.S. banks.

Subscription. The undersigned on behalf of the Sponsor or Organization and the above individuals (collectively "applicants") represents and warrants it is the authorized agent of the applicants and hereby applies and subscribes, for and on behalf of each individual 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 insurance coverage requested above and 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 representative and plan administrator, International Medical Group, Inc. (IMG). The applicants, understand and agree: (I) the insurance applied for is not an employee welfare benefit plan, accident & health product, health insurance, major medical, nor a health plan subject to or complying with U.S. laws, but is intended for use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (II) the applicants must pay premiums for the entire period of coverage in advance, and no coverage will be effective until the required premium has been paid and 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) the Company relies on the accuracy, truthfulness and completeness of the information provided herein and any misrepresentation or omission contained herein will void the insurance contract 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, the applicants 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, 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 the insurance will be in Marion County, Indiana, for which the applicants consent. The applicants consent and agree that Indiana surplus lines law shall govern all rights and claims raised under the insurance contract. **Acknowledgment.** The applicants understand and agree that: (I) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of the applicants and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (II) the 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 time frame outlined in the contract prior to the effective date, 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 applicants, the Company or IMG to be resident, located, or expressly to be performed in any particular jurisdiction, 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 and IMG has no direct or independent liability under any insurance contract. **Authorization for Release of Information.** The applicants 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 them or on their behalf, has any records or knowledge of their health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of them, and any non-medical information about them, to disclose their entire medical record, file, history, medications, and any other information concerning them and to give any and all such information to their agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries. **Certification.** The applicants hereby certify, represent and warrant that: (i) 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 or that they have been read to them, and the applicants understand them, (ii) they are eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) they 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 the applicants foresee may require treatment during the insurance or for which the applicants intend to claim under the insurance, and (iv) each applicant is not hospitalized, disabled, or HIV+. If signed as the legal representative of the applicant, the signer warrants his/her authority and capacity to so act and to bind the applicants. By acceptance of coverage and/or submission of any claim for benefits, each applicant ratifies the authority of the signer to so act and bind that applicant. **The applicants** represent and warrant that under the insurance offered to the applicants, 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 applicants, 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 applicants, beneficiaries and other specified individuals including but not limited to furnishing certain material to all applicants 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 applicants and beneficiaries upon their request; and making certain material available to applicants 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 applicants, beneficiaries and other specified individuals. **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 applicants 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) 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) the applicants understand that it is solely their responsibility to determine if PPACA is applicable to them, and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the applicants may incur, for their failure to obtain coverage required by any applicable law including without limitation PPACA. The Sponsor hereby arranges for insurance to be offered to the applicants, the applicants have voluntarily authorized this action in writing, and the applicants 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. **E-Consent.** The applicants wish to receive information and communicate electronically, and prefer to use email rather than regular mail. The applicants agree IMG, its affiliates, and subsidiaries may provide the recipient with any communications in electronic format, and paper communications are not required, unless and until the applicant withdraws this consent. The applicants unambiguously give consent to the transfer of personal data to entities established in a country outside the EU Member States. This consent is freely given, specific for the administration of coverage and benefits, and an informed indication of the applicants' wishes. The applicants acknowledge and understand the transfer is necessary for the performance of a contract, taken in response to their request, and necessary for the conclusion or performance of a contract concluded in their interest. The applicants also agree it is their responsibility to provide IMG with true, accurate and complete e-mail address, contact, and other information related to the coverage, and to maintain and promptly update any changes in this information 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.

Signature of Responsible Officer X_____	Date: ___/___/___ *(month/day/year)*

IMG Producer Use Only

Producer Number:	16927	Name:	Travel Insurance Center		
Email:	info@travelinsurancecenter.com	Phone Number:	402-343-3699		
Address:	8420 W Dodge Rd - 5th Floor	City:	Omaha	State: NE	Postal Code: 68114