

## PATRIOT INTERNATIONAL RATES

Rates are based on a \$250 deductible option.  
For other deductible options, please see the application.

**ONE MONTH RATES (Five Maximum Limit options.)**  
Maximums are per covered insured per certificate period.)

	Option 5 \$50,000	Option 6 \$100,000	Option 7 \$500,000	Option 8 \$1,000,000	Option 9 \$2,000,000
Age	One Month	One Month	One Month	One Month	One Month
18-29	\$32	\$37	\$43	\$48	\$54
30-39	\$37	\$43	\$57	\$63	\$72
40-49	\$59	\$66	\$73	\$81	\$99
50-59	\$96	\$109	\$122	\$136	\$153
60-64	\$109	\$129	\$153	\$180	\$201
65-69	\$129	\$138	\$158	\$189	\$243
70-79	\$189	N/A	N/A	N/A	N/A
80+*	\$378	N/A	N/A	N/A	N/A
Dep. Child	\$29	\$33	\$39	\$43	\$49
Child Alone	\$32	\$36	\$41	\$46	\$52

\*10,000 Maximum

### DAILY RATES (10 day minimum)

	Option 5 \$50,000	Option 6 \$100,000	Option 7 \$500,000	Option 8 \$1,000,000	Option 9 \$2,000,000
Age	Daily	Daily	Daily	Daily	Daily
18-29	\$1.15	\$1.25	\$1.45	\$1.65	\$1.85
30-39	\$1.25	\$1.45	\$1.95	\$2.15	\$2.45
40-49	\$2.00	\$2.25	\$2.45	\$2.75	\$3.35
50-59	\$3.25	\$3.65	\$4.15	\$4.60	\$5.15
60-64	\$3.65	\$4.35	\$5.15	\$6.05	\$6.75
65-69	\$4.35	\$4.65	\$5.35	\$6.35	\$8.15
70-79	\$6.35	N/A	N/A	N/A	N/A
80+*	\$12.65	N/A	N/A	N/A	N/A
Dep. Child	\$1.00	\$1.10	\$1.30	\$1.45	\$1.65
Child Alone	\$1.15	\$1.25	\$1.35	\$1.55	\$1.80

\*10,000 Maximum

### 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 3 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	\$45
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\*Must be purchased for a minimum of 3 months regardless of the minimum number of days being traveled. Premium is charged in whole month increments.

## PATRIOT AMERICA RATES

Rates are based on a \$250 deductible option.  
For other deductible options, please see the application.

**ONE MONTH RATES (Four Maximum Limit options.)**  
Maximums are per covered insured per certificate period.)

	Option 1 \$50,000	Option 2 \$100,000	Option 3 \$500,000	Option 4 \$1,000,000
Age	One Month	One Month	One Month	One Month
18-29	\$43	\$50	\$64	\$76
30-39	\$56	\$67	\$84	\$97
40-49	\$84	\$96	\$126	\$142
50-59	\$120	\$147	\$178	\$206
60-64	\$142	\$174	\$207	\$248
65-69	\$162	\$208	\$226	\$270
70-79	\$219	N/A	N/A	N/A
80+*	\$381	N/A	N/A	N/A
Dep. Child	\$38	\$45	\$58	\$65
Child Alone	\$39	\$46	\$59	\$66

\*10,000 Maximum

### DAILY RATES (10 day minimum)

	Option 1 \$50,000	Option 2 \$100,000	Option 3 \$500,000	Option 4 \$1,000,000
Age	Daily	Daily	Daily	Daily
18-29	\$1.45	\$1.75	\$2.20	\$2.55
30-39	\$1.90	\$2.25	\$2.85	\$3.25
40-49	\$2.85	\$3.25	\$4.25	\$4.80
50-59	\$4.05	\$4.95	\$6.00	\$6.90
60-64	\$4.80	\$5.85	\$6.95	\$8.35
65-69	\$5.45	\$7.00	\$7.60	\$9.05
70-79	\$7.35	N/A	N/A	N/A
80+*	\$12.75	N/A	N/A	N/A
Dep. Child	\$1.30	\$1.50	\$1.95	\$2.20
Child Alone	\$1.35	\$1.60	\$2.00	\$2.25

\*10,000 Maximum

### 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 3 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	\$45
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\*Must be purchased for a minimum of 3 months regardless of the minimum number of days being traveled. Premium is charged in whole month increments.

All premium rates are effective through 8/1/2012. Rates include surplus lines tax where applicable. A dependent child is your child shown on the Application Form over 14 days and under 18 years of age, traveling with you, and for whom premium has been paid. The maximum amount of coverage for applicants who are 80 years of age or older is \$10,000.

**1. Primary applicant information: Patriot Travel Medical Insurance** Please print legibly and complete ALL SECTIONS (front and back) of this application.  Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Government Issued ID Number \_\_\_\_\_ Country of Citizenship \_\_\_\_\_

Home Country \_\_\_\_\_ Destination Country(ies) \_\_\_\_\_

**Beneficiaries**

In the event of an insured's accidental death and/or common carrier accidental death, beneficiaries will be as follows: **1)** Spouse (if any) - Primary **2)** Children (if any) - First contingent **3)** Estate of the insured - Second contingent

**2. Send Confirmation of Coverage, Fulfillment Kit, and renewal information (if applicable) to:**

**OR**  I will use the Online Fulfillment Kit Option

Name \_\_\_\_\_ Email \_\_\_\_\_

Address, City, State, Country, Postal Code \_\_\_\_\_

If the address in #2 is in Florida, is the applicant currently located in Florida?  Yes  No

(Determines applicable surplus lines tax and will not affect coverage)

**3. Select the coverage plan and plan option. Check one plan and one option.**

- Patriot America for non-U.S. citizens (see page 6) \_\_\_\_\_ → Option Number  1  2  3  4
- Patriot International for U.S. citizens (see page 5) \_\_\_\_\_ → Option Number  5  6  7  8  9
- Citizenship Return Rider: If you are a U.S. citizen and elect this rider, have you resided outside 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

Non-U.S. citizens if replacing current international coverage (see page 7)

Current Carrier: \_\_\_\_\_ Date of arrival in the U.S.: \_\_\_\_\_ OR Expiration date of current coverage: \_\_\_\_\_

**4. Names of Persons to be insured:**

	Date of Birth (month/day/year) REQUIRED	Age	Monthly Rate*	# of months Travel Coverage	Daily Rate*	# of days
Applicant _____	__/__/__	__	X =	_____	X =	_____
Spouse _____	__/__/__	__	X =	_____	X =	_____
Child _____	__/__/__	__	X =	_____	X =	_____
Child _____	__/__/__	__	X =	_____	X =	_____
<b>Please attach additional sheet for more children</b>						
<b>*use applicable monthly and daily rates (see pages 5 and 6)</b>						
			<b>Total (A)</b>	<b>Total (B)</b>		<b>Total (C)</b>

**5. Home Country Coverage** (see page 12 for details)

One month for every five months of purchased Travel Medical coverage up to a maximum of two 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.

Monthly Rate Total (A)	# of Months Home Country Coverage	Total Home Country Coverage Premium
_____	X _____	= _____
		<b>Total (D)</b>

<b>6. CIRCLE ONE</b>	Deductible	Rate Factor	Deductible	Rate Factor
Select one deductible by circling it, then enter the applicable rate factor amount in the premium calculation box in Section 7	\$0	1.25	\$500	.90
	\$100	1.10	\$1000	.80
	\$250	1.00	\$2500	.70

Application Form continued on back

<b>7. (B)</b> Monthly premium total (from Total (B) in Section 4)	
<b>(C)</b> Daily premium total (from Total (C) in Section 4)	+ _____
<b>(D)</b> Home Country Coverage premium total (from Total (D) in Section 5)	+ _____
Deductible rate factor (see Section 6)	x _____
<b>(E) Base premium - enter in the space below</b>	_____ <b>(E)</b>
<b>Adventure Sports Rider</b> enter .20 if applicable	
<b>Citizenship Return Rider</b> enter .05 if applicable	+ _____
<b>(F) Total Rider factor enter in space below to the right of the 1.</b>	= _____ <b>(F)</b>
<b>Enhanced AD&amp;D Rider</b> - To purchase please complete the following calculation:	
_____ X _____ = _____	<b>(G)</b>
# of months	Rate from page 5/6
<b>Enter (G) in the space below</b>	
<b>Evacuation Plus Rider</b> - To purchase please complete the following calculation:	
_____ X _____ X \$45.00 = _____	<b>(H)</b>
# of months	# of insureds
<b>Enter (H) in the space below</b>	
<b>Patriot T.R.I.P. Lite</b> - To purchase please complete the following calculation:	
_____ ÷ 100 = _____ X 4.52 = _____	<b>(I)</b>
Total cost of trip for all travelers (minimum \$500)	
<b>Enter (I) in the space below</b>	
<b>(E) Enter the amount from E</b>	_____
<b>(F) Enter the amount from F to the right of the 1.</b>	x <b>1.</b> _____
<b>(G) Enter the amount from G</b>	+ _____
<b>(H) Enter the amount from H</b>	+ _____
<b>(I) Enter the amount from I</b>	+ _____
<b>\$20 optional express mail</b>	+ _____
<b>TOTAL AMOUNT DUE</b>	= _____

IMG Producer Use Only	
Producer#	_____
GA#	_____
Name	_____
Address	_____
City, State, Zip	_____
Phone:	_____

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.

**8. 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 Travel Medical Insurance as underwritten and offered by Sirius International Insurance Corporation (publ) (the Company) on the date of receipt hereof. 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 invoke the benefits and protections of its laws, 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 court action or administrative 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 law shall govern all rights and claims raised under the Certificate of Insurance issued to me (us).

**ACKNOWLEDGEMENT** I (we) understand and agree that: (i) the insurance 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 condition, disorder 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 and time of this insurance, including any subsequent, chronic or recurring complications or consequences related thereto or arising therefrom, whether or not previously manifested or symptomatic, diagnosed, treated, or disclosed prior to the effective date (a "pre-existing condition"), and that all charges and/or claims 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 plan, is solely liable for the coverages and benefits to be provided under the insurance contract.

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

**CERTIFICATION** I (we) hereby certify, represent and warrant that: (i) I (we) have read the foregoing statements and the brochure 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 guardian or proxy 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.

**FOR PATRIOT T.R.I.P. LITE (only applicable if applicant has completed section 7H):**

**MEMBERSHIP** I (we) hereby apply for membership to NSBTHA.

**CERTIFICATION** I (we) hereby certify 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 Program Cost, coverage will begin at 12:01 a.m. on the day after this completed application is received. I (we) understand that if payment is returned unpayable for any reason, coverage becomes null and void.

**X Signature of Insured or Proxy (Required)** \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_

- 9. Payment Method**
- Check (To IMG)     Wire     Money Order (To IMG)
  - MasterCard     Visa     American Express
  - Discover     JCB    eCheck (ACH) available online

*If paying by credit card, I authorize IMG to debit my credit card account for the total charge as specified in Total Amount. Coverage purchased by credit card is subject to validation and acceptance by credit card company. I agree to comply with the cardholder agreement. For your convenience, only one payment for the total amount due is required. You agree and understand that if your purchase includes Patriot T.R.I.P. Lite, the cost for this program will be allocated directly to iTravelInsured.*

Card# \_\_\_\_\_ Expiration date \_\_\_\_\_

Name on Card \_\_\_\_\_

Signature \_\_\_\_\_

Your Daytime Phone \_\_\_\_\_

Your Billing Address \_\_\_\_\_