

**To Enroll** - 1. Complete entire Application Form (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 or fax to:

Sponsoring Organization \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Contact Name \_\_\_\_\_

**Requested Effective Date** \_\_\_\_\_

Date of Departure \_\_\_\_\_

Requested Expiration Date \_\_\_\_\_

Purpose of Trip \_\_\_\_\_

Destinations \_\_\_\_\_

**We will use the Online Fulfillment Kit Option (see page 8 for details-an email address is required)**

Email: \_\_\_\_\_

### 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

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

*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 \_\_\_\_\_

Authorized Signature \_\_\_\_\_

Cardholder's Daytime Phone \_\_\_\_\_

Cardholder's Billing Address \_\_\_\_\_

## Sponsor's Agreement - Proxy Statement

**1. Subscription.** The Sponsoring Organization (Sponsor) hereby applies and subscribes, for and on behalf of and as authorized agent and proxy for each of the group members listed on the Application Form on the reverse side hereof, to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN for Patriot Group Travel Medical Insurance (Group Insurance) 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 and all such members understand and agree: (i) the insurance applied for is not general health insurance, but is intended for the members' use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) 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, (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, the Sponsor and all group members purposefully initiate and take advantage of the privilege of conducting business with the Company in Indiana, through IMG as its agent and 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(s) 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 the Sponsor and all group members hereby expressly consent. We consent and agree that Indiana law shall govern all rights and claims raised under the Certificate of Insurance.

**2. Acknowledgment.** The Sponsor and all group members understand and agree that: (i) the insurance agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of the Sponsor and such members, (ii) the Group 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 of the 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 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 group members, 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. Medical Release.** The Sponsor and all group members hereby authorize any doctor, practitioner of the healing arts, hospital, clinic, healthcare related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, and employee or benefit plan administrator having information as to any of the group members' care, advice, treatment, evaluation, diagnosis or prognosis for any physical or mental condition, or financial and employment status, to provide such information to IMG and the Company.

**4. Certification.** The Sponsor and all group members hereby certify, represent and warrant that they have read the foregoing statements and the Group Insurance brochure (or same have been read or provided to such members), and they understand them, and that each group member listed: (i) is eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable 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 representative of the Sponsor and as proxy for each of the group members, the undersigned warrants his/her authority and capacity to so act and to bind the Sponsor and such members. By acceptance of coverage and/or submission of any claim for benefits, each group member ratifies and affirms the authority of the signer and Sponsor to so act and bind the member.

**5. Payment.** Sponsor agrees to pay the required insurance premiums to IMG, as agent for the Company, on or before the due date(s). If the premiums are to be paid in installments, a grace period of 10 calendar days will be allowed for IMG's actual receipt of payment of each premium, except the initial installment. If any premiums are unpaid at the end of the grace period, the insurance coverage shall lapse and terminate with respect to any group member for whom such premium is unpaid, effective as of the initial due date of the premium, whereupon the Company's liability shall cease with respect to all charges and/or claims incurred by such member(s) thereafter. All premium payments must be made in U.S. dollars. If paying by credit card, the Sponsor authorizes IMG to charge/debit Sponsor's MasterCard, Visa, American Express, Discover or JCB account for the total amount of premiums due. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. In the event Sponsor has chosen to pay premiums on an installment basis, Sponsor hereby pre-authorizes future credit card payment installments for the balance of the period of coverage, and hereby requests and authorizes IMG to charge/debit Sponsor's credit card periodically as and when premium payment installments become due. This authorization will remain in effect until revoked by Sponsor in writing, and until IMG actually receives notice of revocation.

**6. FOR PATRIOT T.R.I.P. LITE (only applicable if applicant has completed section 6F): Membership** Each group member hereby applies for membership to NSBTHA.

**Certification** Each group member hereby certifies that he/she has read, or has had read to him/her, all statements on this application, and represents that the responses are true, complete and correctly recorded; and that all listed on this application are medically able to travel on the date this program is purchased. Each one understands and agrees 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. Each group member understands that if payment is returned unpayable for any reason, coverage becomes null and void.

**Signature (Required)** \_\_\_\_\_

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

1. Group Member's Name		Date of Birth	Government Issued ID Number	Group Member's requested Effective date, EXpiration date and/or DEparture date, if different than dates on the reverse side	Monthly Rate*	Daily Rate*
Country of Citizenship	Home Country					
<input type="checkbox"/> 1				EF: EX: DE:		
<input type="checkbox"/> 2				EF: EX: DE:		
<input type="checkbox"/> 3				EF: EX: DE:		
<input type="checkbox"/> 4				EF: EX: DE:		
<input type="checkbox"/> 5				EF: EX: DE:		
<input type="checkbox"/> 6				EF: EX: DE:		
<input type="checkbox"/> 7				EF: EX: DE:		
<input type="checkbox"/> 8				EF: EX: DE:		
<input type="checkbox"/> 9				EF: EX: DE:		
<input type="checkbox"/> 10				EF: EX: DE:		
<input type="checkbox"/> 11				EF: EX: DE:		

\*Please check the box in front of the applicant's name to identify the Chaperone/Faculty Leader (if the Chaperone Rider is selected)

(attach additional sheets if necessary)  
\*use applicable monthly/daily rates (see pages 5 or 6)

2.                      X                      =                           **SUBTOTALS:      A      B**  
 Subtotal A (from Subtotal A to the right) # of months      **Total A** ←  
                     X                      =                       
 Subtotal B (from Subtotal B to the right) # of days      **Total B** (continue to box below) ←

3. Select the coverage plan and plan option. (Check one plan and one option):

**Patriot America Group for non-U.S. citizens**  
 (see page 6) Option Number: 1\_\_ 2\_\_ 3\_\_ 4\_\_

**Non-U.S. citizens if replacing current international coverage**  
 Current Carrier \_\_\_\_\_  
 (see page 7 for details)  
 Date of arrival in the U.S. \_\_\_\_\_ OR  
 Expiration date of current coverage \_\_\_\_\_

**Patriot International Group for U.S. citizens**  
 (see page 5) Option Number: 5\_\_ 6\_\_ 7\_\_ 8\_\_ 9\_\_

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

5. Home Country Coverage (HCC) (see page 11 for details)  
 One month for every five months of purchased Travel Medical coverage up to a maximum of two months of HCC.  
 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.

To Pay in Monthly Installments (please first calculate your total premium in Section 6 of the Application)

                     ÷                      =                       
 Total Premium      Number of months

+ \$10.00 = \$                      (Minimum initial payment required)  
 Billing fee      Periodic payment

Monthly Rate	# of Months HCC Coverage	Total HCC Premium
<u>                    </u>	X <u>                    </u>	= <u>                    </u>
		<b>Total (C)</b>

Please complete and return the front and back sides of this application.

6. (A) Monthly premium total (from Total (A) in Section 2) \_\_\_\_\_  
 (B) Daily premium total (from Total (B) in Section 2) + \_\_\_\_\_  
 (C) HCC premium total (from Total (C) in Section 5) + \_\_\_\_\_  
 = \_\_\_\_\_  
 Deductible rate factor (see Section 4) X \_\_\_\_\_  
**(D) Base premium - enter in the space below** \_\_\_\_\_

**Adventure Sports Rider**  
 enter .20 if applicable \_\_\_\_\_  
**Citizenship Return Rider**  
 enter .05 if applicable + \_\_\_\_\_  
 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.  
**Chaperone Rider**  
 enter .10 if applicable + \_\_\_\_\_  
**(E) Total Rider factor go to space below and place this factor to the right of the 1.** = \_\_\_\_\_

**Patriot T.R.I.P. Lite** - To join NSBTHA and to purchase this option, please complete the following calculation:  
                     ÷ 100 =                      X 4.52 =                       
 Total cost of trip for all travelers (minimum \$500) (F)  
**Enter (F) in the space below**

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

**IMG Producer Use Only**

Producer# 51855  
 GA# \_\_\_\_\_  
 Name Insubuy, Inc.  
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 Plano TX  
 City, State, Zip 75093  
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