

1. Primary applicant information: Passport Protection Plus Please print legibly and complete ALL SECTIONS (front and back) of this application. Male Female

Last Name _____ First Name _____ Middle _____
 Passport Number, SSN, or Driver's License _____ Issuing Country _____
 Home Country _____ Destination Country(ies) _____

Please indicate beneficiaries for the accidental death and common carrier accidental death benefits. Unless indicated otherwise, the Applicant will be deemed the beneficiary for his/her spouse and children.

Beneficiary for Applicant _____ Relationship to Applicant _____
 Beneficiary for Spouse/Children _____ Relationship to Spouse/Children _____

2. Send Confirmation of Coverage, Fulfillment Kit, and renewal information (if applicable) to:
OR I will use the Online Fulfillment Kit Option (see page 14 for details-an email address is required)

Name _____ E-mail _____
 Address, City, State, Country, Postal Code _____

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

- Protection America for non-US citizens**
 Option Number: 1__ 2__ 3__ 4__
 Applicants over age 65 (see page 16 for details)
 Current Carrier _____
 Date of arrival in the U.S. _____ **OR**
 Expiration date of current coverage _____
- Protection International for US citizens**
 Option Number: 5__ 6__ 7__ 8__ 9__

4. Names of Persons to be insured:	Date of Birth (month/day/year) REQUIRED	Age	Monthly Rate*	# of months	Daily Rate*	# of days
Applicant _____	__/__/__	__	_____	X = _____	_____	X = _____
Spouse _____	__/__/__	__	_____	X = _____	_____	X = _____
Child _____	__/__/__	__	_____	X = _____	_____	X = _____
Child _____	__/__/__	__	_____	X = _____	_____	X = _____
					Total (A)	Total (B)

Please attach additional sheet for more children
 *use applicable monthly and daily rates (see pages 6 and 8)

5. (month / day / year)
 Requested effective date (see How to Enroll, page 15): __/__/__
 Date of departure from your Home Country: __/__/__
 Date of return to Home Country: __/__/__
 Home Country Coverage (if applicable, enter number of extra coverage months here ____; see page 5 for details)

6. 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 7	US\$0	1.25
	US\$100	1.10
	US\$250	1.00
	US\$500	.90
	US\$1000	.80
	US\$2500	.70

Application Form continued on back

7. (A) Monthly premium total
(from Total (A) in Section 4) _____

(B) Daily premium total
(from Total (B) in Section 4) + _____

= _____

Deductible rate factor
(see Section 6) X _____

Base premium = _____

Coinsurance buy-up X **1.05** _____

(C) Total- enter in space below = _____

Leisure Sports Rider
enter .20 if applicable + _____

Protection Return Rider
enter .05 if applicable + _____

(D) Total Rider factor
go to space below and place = _____
this factor to the right of the 1.

Patriot T.R.I.P. Lite
To purchase this option, please complete the following calculation:
_____ ÷ 100 = _____ X 4.52 = _____
Total cost of trip (E)
for all travelers
Enter (E) in the space below

Extreme Sports Rider - To purchase this option, please complete the following calculation:
_____ X _____ X _____ = _____
Number of travelers Number of months Rate (F)
who require this rider from
page 10
Enter (F) in space below

Enhanced AD&D Rider - To purchase this option, please complete the following calculation:
_____ X _____ = _____
Number of months Rate from page 11 (G)
Enter (G) in space below

(C) Enter the amount from C _____

(D) Enter the amount D from
above to the right of the 1. X **1.** _____

= _____

(E) Enter the amount from E + _____

(F) Enter the amount from F + _____

(G) Enter the amount from G + _____

US\$20 *optional* express mail + _____

TOTAL PREMIUM DUE = _____

Selling 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 Community Trust & Investment Co., Noblesville, IN, for Passport Protection Plus 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 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 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 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.

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 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, (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.

X Signature of Insured or Proxy _____

Date _____ Phone _____

9. Payment Method Check (To IMG) Money Order (To IMG)

MasterCard Visa American Express

Discover JCB

If paying by credit card, I authorize IMG to debit my credit card account for the total charge as specified in Total Premium. Coverage purchased by credit card is subject to validation and acceptance by credit card company. I agree to comply with the cardholder agreement.

Card# _____ Expiration date _____

Name on Card _____

Signature _____

Your Daytime Phone _____

Your Billing Address _____
