

**Applicant information: Please print legibly and complete ALL SECTIONS of this application.**

**Visitors Care®**

(Circle one) Mr. Mrs. Ms.  Male  Female  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
 Government Issued ID Number \_\_\_\_\_ Country of Citizenship \_\_\_\_\_ Home Country \_\_\_\_\_  
 Destination Country \_\_\_\_\_

**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**

**Send Confirmation of Coverage and Fulfillment Kit to:**  I will use the Online Fulfillment Kit Option (see page 12 for details)

Name \_\_\_\_\_ E-mail \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_

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

**Calculating Your Premium:**

Select the coverage plan and plan option:

**Visitors Care** Plan A: \_\_\_Option 1 \_\_\_Option 2 \_\_\_Option 3  
 Plan B: \_\_\_Option 4 \_\_\_Option 5 \_\_\_Option 6  
 Plan C: \_\_\_Option 7 \_\_\_Option 8 \_\_\_Option 9

**Applicants over age 65**  
 Current Carrier \_\_\_\_\_  
 (see page 8 for details)  
 Date of arrival in the U.S. \_\_\_\_\_ **OR**  
 Expiration date of current coverage \_\_\_\_\_

**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	=

**Requested Effective Date** (see How to Enroll section): \_\_\_/\_\_\_/\_\_\_  
 Date of Departure: \_\_\_/\_\_\_/\_\_\_  
 Date of Arrival in USA: \_\_\_/\_\_\_/\_\_\_  
 Date of Return to Home Country: \_\_\_/\_\_\_/\_\_\_

Please attach additional sheet for more children

	Total (A)		Total (B)	
_____ + _____ = _____ + _____ = _____				
(A) total monthly premium (from Total (A) above)		(B) total daily premium (from Total (B) above)		\$20.00 Optional Express, Fax confirmation or Special Correspondence

**SUBSCRIPTION I** (we) hereby apply and subscribe to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, for Visitors Care 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 \_\_\_\_\_

Payment must be made for the total number of months you want coverage. Refund of premium will be made only if a written request is received by IMG as explained in the "Quality Guarantee" section on page 9. All payments must be made in US dollars and drawn on US banks.

**Payment Method**  Check (To IMG)  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 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# \_\_\_\_\_ Exp. date \_\_\_\_\_  
 Name on Card \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Your Daytime Phone \_\_\_\_\_

**Selling Producer Use Only**

Producer# \_\_\_\_\_ GA# 51855 \_\_\_\_\_  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Phone: \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_