Disclaimer

Insurance can be effective only after the underwriting department receives and reviews your application with the legal department, which can take 3 to 5 business days.

Underwriting department and legal department are open during regular business hours from Monday through Friday.

By submitting this paper application, you acknowledge and agree that:

- Back dated applications are not possible.
- Insurance coverage is not guaranteed to be approved for every person that submits the application.
- You hold Insubuy and the writing agent (if any) harmless and relieve us from any liability because of this.

If the above terms are not acceptable to you, please do not submit the application.

If you need to purchase the insurance urgently, please call our office at +1 (866) INSUBUY or the writing agent to confirm, before sending the application.

Insubuy®, Inc. 4200 Mapleshade Ln, Suite 200, Plano, TX 75093
Phone: +1 (866) INSUBUY | Fax: (972) 767-4470 | info[at]insubuy.com

GlobeHopper℠ Senior

Travel Insurance Application

Please print legibly and complete ALL SECTIONS of this application.

1. **Primary applicant information:** ☐ Male ☐ Female

   Last Name _____ First Name _____ Middle _____

   Government Issued ID Number _____ Country of Citizenship _____

   Home Country _____ Primary Destination Country _____

   Beneficiaries: Primary Beneficiary _____ Contingent Beneficiary _____

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

   Name _____ Email _____

   Address, City, State, Country, Postal Code _____

   _____

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

   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.**

   ☐ **Single-Trip Plan:** Option Number ☐ 1* - $50,000 ☐ 2* - $100,000 ☐ 3 - $500,000 ☐ 4 - $1,000,000

   ☐ **Multi-Trip Plan:** Option Number ☐ 5* - $1,000,000

   **Age 80+ are limited to options #1, #2 and #5 and the maximum coverage amount is $100,000.*

4. **Eligibility *(If you answer No to either question, you are ineligible.)***

   Are you currently enrolled in Medicare Parts A&B? ☐ Yes ☐ No

   Do you own a Medicare Supplement or Medicare Advantage Plan? ☐ Yes ☐ No

5. **Effective date & dates of travel**

   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

APPLICATION FORM CONTINUED ON THE NEXT PAGE

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6. **Premium Rate calculations**

Single-Trip Plan **(Use applicable daily and/or monthly rates.)**

Names of Persons to be Insured:	Date of Birth:	Age	Monthly Rate:	# of Months Travel Coverage:		Daily Rate:	# of Days Travel Coverage:	
Applicant _____	____/____/____	____	_____	x _____ =	_____	_____	x _____ =	_____
Spouse _____	____/____/____	____	_____	x _____ =	_____	_____	x _____ =	_____

Estimated Premium for All Insureds = _____ (A)

Multi-Trip Plan (Use applicable annual rate.)

Names of Persons to be Insured:	Date of Birth:	Age	# of Insured:	Annual Rate:		Total Rate:
Applicant _____	____/____/____	____	1	X $190	=	_____
Spouse _____	____/____/____	____	1	X $190	=	_____

Estimated Premium for All Insureds = _____ (A)

Optional Evacuation Plus Rider (Multi-Trip Plan only. Must include all covered applicants if selecting.)

# of Insured:	Annual Rate:		Total Rate:
_____	X $285	=	_____ (B)

7. **Deductible Rate Factor – Single-Trip Plan only**

Select and circle one deductible, then enter the applicable rate factor amount in the premium calculation box in Section 8.

☐ $0* | 1.25 ☐ $100* | 1.10 ☐ $250 | 1.00 ☐ $500 | .90 ☐ $1,000 | .80 ☐ $2,500 | .70

**Only available with Option 1 - $50,000 or Option 2 - $100,000 lifetime maximum amounts.*

8. **Premium calculation**

Estimated Premium Total (from (A) in Section 6)		_____
Deductible Rate Factor (from Section 7)	x	_____
Estimated Premium	=	_____
Optional Evacuation Plus Rider (Multi-Trip Plan only. Must include all covered applicants if selecting.) (from (B) in Section 6)	+	_____
Optional $20 Express Mail Delivery	+	_____
TOTAL PREMIUM DUE	=	_____

IMG® PRODUCER USE ONLY

Producer # 51855

GA # _____

Name _____

Address 4200 Mapleshade Ln, Suite 200

City, State, Zip _____

Phone +1 (866) INSUBUY

Email info[at]insbuy.com

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All payments must be made in U.S. dollars and drawn on U.S. banks.

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 GlobeHopper Senior Travel 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, 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 surplus lines 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 producer/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 disorder, condition 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, 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 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.

AUTHORIZATION FOR RELEASE OF INFORMATION I (we) 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 me or on my behalf, has any records or knowledge of my health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to disclose my entire medical record, file, history, medications, and any other information concerning me and to give any and all such information to my agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

CERTIFICATION I (we) hereby certify, represent and warrant that: (i) I (we) 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 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 the legal representative 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.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) I (we) 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) our 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) I (we) understand that it is solely my responsibility to determine if PPACA is applicable to us, and the Company and IMG shall have no liability whatsoever, including for any penalties that you may incur, for your failure to obtain required or compliant coverage.

CERTIFICATION I (we) hereby certify, represent, and warrant 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 not currently hospitalized, disabled or HIV+ and will be medically able to travel on the requested effective date. 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 premium is returned unpayable for any reason, coverage becomes null and void. I acknowledge and understand that if not completely satisfied after receiving the insurance contract, the insured person may request cancellation of the insurance retroactive to the effective date by sending a written request to the Company within the review period outlined in the insurance contract, and thereby receive a refund of premium paid. I wish to receive information and communicate electronically, and prefer to use my email address rather than regular mail. I agree IMG may provide me with any communications in electronic format, and IMG is not required to send paper communications to me, unless and until I withdraw this consent. I also agree it is my 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.

Signature of Insured or Legal Representative (Required) _____

Date _____/_____/_____ Phone _____

Payment Method

- ☐ Check (to IMG)
- ☐ Wire
- ☐ Money Order (to IMG)
- ☐ MasterCard
- ☐ Visa
- ☐ American Express
- ☐ Discover
- ☐ JCB
- ☐ eCheck (ACH) Available Online

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. 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 _____/_____/_____

Cardholder Name _____

Signature _____

Cardholder Phone and Email _____

Cardholder Billing Address _____