Insubuy®, Inc 4700 Dexter Dr. Suite 100 Plano TX 75093 | Fax: (972) 767-4470 | Phone: (866) INSU-BUY

1. Primary applicant information: Outreach 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 ***(see Certificate Wording for Beneficiary designation)***

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 ***(see page 9 for details - an email address is required)***

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.

☐ Outreach America for non-U.S. citizens *(see page 6)* → Option Number ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Outreach 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_____	=_____

Please attach additional sheet for more children
***use applicable monthly and daily rates (see pages 5 and 6)**

_____ Total (A) _____ Total (B) _____ Total (C)

5. End of Trip Home Country Coverage *(see page 13 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	_____	=	_____ Total (D)

6. CIRCLE ONE

Select one deductible by circling it, then enter the applicable rate factor amount in the premium calculation box in Section 7

Deductible	Rate Factor	Deductible	Rate Factor
$0	1.25	$500	.90
$100	1.10	$1000	.80
$250	1.00	$2500	.70

Application Form continued on back

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

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

(D) End of Trip Home Country Coverage premium total (from Total (D) in Section 5) +_____

Deductible rate factor (see Section 6) x_____

(E) Base premium - enter in the space below =_____ **(E)**

Adventure Sports Rider enter .20 if applicable _____

Citizenship Return Rider enter .05 if applicable +_____

(F) Total Rider factor enter in space below to the right of the 1. =_____ **(F)**

Enhanced AD&D Rider - To purchase please complete the following calculation:

_____ X _____ = _____ **(G)**
# of months; Rate from page 5/6

Enter (G) in the space below

Evacuation Plus Rider - To purchase please complete the following calculation:

_____ X _____ X $45.00 = _____ **(H)**
# of months; # of insureds

Enter (H) in the space below

Patriot T.R.I.P. Lite - To purchase please complete the following calculation:

_____ ÷ 100 = _____ X 4.35 = _____ **(I)**
Total cost of trip for all travelers *(minimum $500 per traveler)*

Enter (I) in the space below

(E) Enter the amount from E _____

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

=_____

(G) Enter the amount from G +_____

(H) Enter the amount from H +_____

(I) Enter the amount from I +_____

$20 *optional* express mail +_____

TOTAL AMOUNT DUE =_____

insubuy.com

IMG Producer Use Only

Producer# 51855

GA# 51855

Name Insubuy, Inc.

Address 4700 Dexter Dr, Suite 100

City, State, Zip Plano TX 75093

Phone (866) INSU-BUY

0314

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 Outreach 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 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 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.

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.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) I 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 will require U.S. citizens and certain U.S. residents to obtain PPACA compliant insurance coverage unless they are exempt from PPACA, and penalties may be imposed on U.S. citizens and U.S. residents who are required to maintain PPACA compliant coverage but do not do so, (iii) my 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 understand that it is solely my responsibility to determine if PPACA is applicable to me.

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

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 Due. Coverage purchased by credit card is subject to validation and acceptance by credit card company. By signing this form, Applicant represents and warrants that he/she has the cardholder's authorization to use the card and, if not, will take full responsibility for the payment and any charges accruing to it. 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_____

Cardholder Name_____

Signature_____

Cardholder Daytime Phone_____

Cardholder Billing Address_____