INSUBUY, 4700 Dexter Dr, Suite 100, Plano, TX 75093 | Fax: (972) 767-4470: Phone: (866) INSUBUY
Or scan and return by email to: info [at] insubuy.com

# PATRIOT TRAVEL MEDICAL INSURANCE® APPLICATION

Please print legibly and complete ALL SECTIONS *(front and back)* of this application.

IMG

## 1 PRIMARY APPLICANT INFORMATION:

| | | | |
|---|---|---|---|
| ☐ Male ☐ Female | First Name: | Last Name: | Middle: |
| Government Issued ID Number: | | Country of Citizenship: | |
| Country of Residence: | | Destination Country(ies): | |

## 2 FULFILLMENT AND INFORMATION DELIVERY METHOD:

☐ **Communications should be sent via email to:**

☐ **For mail fulfillment kit, and renewal information** *(if applicable)*: **I do not mind the delays associated with receiving the initial communication via regular mail. I prefer to receive a paper copy of the coverage verification letter and insurance contract to the following address:**

| | | |
|---|---|---|
| Name: | | Address: |
| City: | Postal Code: | Country: |

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

## 3 PLAN OPTION AND ADDITIONAL COVERAGE OPTIONS:

Select the coverage plan and maximum limit. Check one plan and one option:

| | |
|---|---|
| ☐ Patriot America for non-U.S. citizens: | ☐ $50,000 ☐ $100,000 ☐ $500,000 ☐ $1 Million |
| ☐ Patriot International for U.S. citizens: | ☐ $50,000 ☐ $100,000 ☐ $500,000 ☐ $1 Million ☐ $2 Million |

Select additional coverage option *(optional)*:
☐ Citizenship Return Rider:
*If you are a U.S. citizen and elect this rider, have you resided outside of 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)* |

Are you a non-U.S. citizen replacing current international coverage? ☐Yes ☐No

| | | |
|---|---|---|
| Current carrier: | Date of arrival in the U.S.: | Expiration date of current coverage: |

## 4 PREMIUM CALCULATION:

| Names of Persons to be insured: *Please attach additional sheet for more children* | | Date of Birth *(month/day/year)* | Monthly Rate | # of Months Travel Coverage | Total | Daily Rate | # of Days | Total |
|---|---|---|---|---|---|---|---|---|
| Applicant | | ___/___/___ | _____ x _____ = _____ | | | _____ x _____ = _____ | | |
| Spouse | | ___/___/___ | _____ x _____ = _____ | | | _____ x _____ = _____ | | |
| Child 1 | | ___/___/___ | _____ x _____ = _____ | | | _____ x _____ = _____ | | |
| Child 2 | | ___/___/___ | _____ x _____ = _____ | | | _____ x _____ = _____ | | |
| | | **TOTAL** | **(A)** _____ | | **(B)** _____ | | | **(C)** _____ |

## 5 DEDUCTIBLE OPTION:

**CIRCLE ONE :**
Select one deductible by circling it, then enter the applicable rate factor amount in the premium calculation box in Section 7 **(D)**

| Deductible | $0 | $100 | $250 | $500 | $1,000 | $2,500 |
|---|---|---|---|---|---|---|
| Rate Factor | 1.25 | 1.10 | 1.00 | .90 | .80 | .70 |

## 6 END OF TRIP HOME COUNTRY COVERAGE *(optional)*:

One month for every six months of consecutive coverage up to a maximum of two months of End of Trip Home Country Coverage

Coverage can continue for up to one or two months after returning to the Home Country or until the termination date.

| Monthly Rate Total (A) | # of Months Home Country Coverage | Total Home Country Coverage Premium |
|---|---|---|
| _____ X | _____ = | _____ |
| **Total** | | **(E)** _____ |

**Beneficiaries**
*If applicants would like to designate a beneficiary, the beneficiary designation form can be accessed via myimg.imglobal.com*

APPLICATION FORM CONTINUED ON BACK

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## 7 PLAN PREMIUM:

| BASE PLAN | |
|---|---|
| **(B)** Monthly premium total *(from B in Section 4)* | |
| **(C)** Daily premium total *(from C in Section 4)* | |
| **(E)** End of Trip Home Country Coverage premium total *(from E in Section 6)* | |
| **B + C + E =** | |
| **(D)** Deductible rate factor *(see Section 5)* | x |
| **(F)** Base premium | |

| ADDITIONAL COVERAGE OPTIONS | |
|---|---|
| **Adventure Sports Rider** *(enter .20 if applicable)* | |
| **Citizenship Return Rider** *(enter .05 if applicable )* | + |
| **(G) Total Rider Factor** | = |

**Enhanced AD&D Rider**
*(To purchase, please complete the following calculation)*

____ # of months x ____ Rate = ____ **(H)**

**Evacuation Plus Rider**
*(To purchase, please complete the following calculation)*

____ # of months x ____ # of Insureds x $45.00 = ____ **(I)**

| TOTAL PREMIUM | |
|---|---|
| *Enter the amount from* **(F)** | |
| *Enter the amount from* **(G)** to the right of the **1.** | x **1.** = |
| *Enter the amount from* **(H)** | + |
| *Enter the amount from* **(I)** | + |
| *Optional* express mail $20 | + |
| **TOTAL AMOUNT DUE** | = |

| IMG PRODUCER USE ONLY | | |
|---|---|---|
| Producer #: 51855 | | |
| Name: Insubuy, Inc. | | |
| Address: 4700 Dexter Dr, Suite 100 | | |
| | | |
| City: Plano | State: TX | Zip: 75093 |
| Phone: (866) INSUBUY | | |
| Email: | | |

## 8 SUBSCRIPTION:

The undersigned on behalf of the above individuals (applicants) hereby apply and subscribe to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for the insurance coverage requested above and as underwritten and offered by Sirius International Insurance Corporation (publ) (the Company) on the date of receipt hereof and as administered by the Company's authorized representative and plan administrator, International Medical Group, Inc. (IMG). The applicants understand and agree: (i) the insurance applied for is not an employee welfare benefit plan, accident & health product, health insurance, major medical, nor a health plan subject to or complying with U.S. laws, but is intended for use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) The applicants must pay premiums for the entire period of coverage in advance, and no coverage will be effective until the required premium has been paid and 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) the Company relies on the accuracy, truthfulness, and completeness of the information provided herein and any misrepresentation or omission contained herein will void the insurance contract and any and all claims and benefits thereunder will be forfeited and waived, (v) by submission of this application and/or any future claim for benefits. The applicants 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 legal proceeding relating to the insurance will be in Marion County, Indiana, for which the applicants hereby consent. The applicants consent and agree that Indiana surplus lines law shall govern all rights and claims raised under the insurance contract. **ACKNOWLEDGEMENT**. The applicants understand and agree that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of applicants and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) the 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 time frame outlined in the contract prior to the effective date, 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 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 applicants, the Company or IMG to be resident, located, or expressly to be performed in any particular jurisdiction, 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 and IMG has no direct or independent liability under any insurance contract. **AUTHORIZATION FOR RELEASE OF INFORMATION**. The applicants 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 them or on their behalf, has any records or knowledge of their health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of them, and any non-medical information about me, to disclose their entire medical record, file, history, medications, and any other information concerning them and to give any and all such information to their agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries. **CERTIFICATION**. The applicants hereby certify, represent and warrant that : (i) they 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 them, and the applicants understand them, (ii) they are eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) they 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 the applicants foresee may require treatment during the insurance or for which the applicants intend to claim under the insurance, and (iv) each applicant is not hospitalized, disabled, or HIV+. If signed as the legal representative of the applicant, the signer warrants their authority and capacity to so act and to bind each applicant. By acceptance of coverage and/or submission of any claim for benefits, each applicant ratifies the authority of the signer to so act and bind the applicants. **IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)**: This insurance is not subject to, and does not provide benefits required by, PPACA. 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. Penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so. Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely the applicants' responsibility to determine the insurance requirements applicable to them and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the applicants may incur, for their failure to obtain coverage required by any applicable law including without limitation PPACA. **E-CONSENT**. The applicants wish to receive information and communicate electronically, and prefer to use an e-mail address rather than regular mail. The applicants agree IMG, its affiliates, and subsidiaries may provide each insured person with any communications in electronic format, and paper communications are not required, unless and until the applicant withdraws this consent. The applicants unambiguously give consent to the transfer of personal data to entities established in a country outside the EU Member States. This consent is freely given, specific for the administration of coverage and benefits, and an informed indication of the applicants' wishes. The applicants acknowledge and understand the transfer is necessary for the performance of a contract, taken in response to their request, and necessary for the conclusion or performance of a contract concluded in their interest. The applicants also agree it is their 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. 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.

| **Signature of Insured or Proxy** *(Required)* | X |
|---|---|
| Date: __/__/__ *(month/day/year)* | Phone: |

## 9 PAYMENT METHOD:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ JBC ☐ Wire ☐ Check (To IMG) ☐ Money Order (To IMG) ☐ *eCheck (ACH) (available upon request)*

*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.*

| Card #: | Expiration Date: __/__/__ *(month/day/year)* | Cardholder Name: |
|---|---|---|
| Signature: *(Required)* | Cardholder Daytime Phone: | Email: |
| Cardholder Billing Address: | | |

*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.*

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