Visitors Care®

APPLICATION FORM

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

(Circle one) Mr. Mrs. Ms. ❑ Male ❑ Female

Last Name_____First Name_____Middle_____

Government Issued ID Number_____Country of Citizenship_____**Home Country**_____

Beneficiary for Applicant_____Relationship to Applicant_____

Destination Country(ies)_____ *Please indicate beneficiaries for the common carrier accidental death benefits. Unless indicated otherwise, the Applicant will be deemed the beneficiary for his/her spouse and children.*

Send Confirmation of Coverage and Fulfillment Kit to: ❑ **I will use the Online Fulfillment Kit Option** *(see page 9 for details - email address required)*

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, plan option and whether you would like the optional rider.

Plan A: ❑Option 1 ❑Option 2 ❑Option 3	**Plan B:** ❑Option 4 ❑Option 5 ❑Option 6	**Plan C:** ❑Option 7 ❑Option 8 ❑Option 9	❑Optional Rider

Requested Effective Date *(see How to Enroll Section)*: ____/____/____ month/day/year Date of Arrival in USA: ____/____/____ month/day/year

Date of Departure from your Home Country: ____/____/____ month/day/year Date of Return to your Home Country: ____/____/____ month/day/year

❑ **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_____	=_____

Please attach additional sheet for more children

Total (A) **Total (B)**

_____+ _____= _____x **1.29** = **(Optional rider)**

(A) total monthly premium (from Total (A) above) (B) total daily premium (from Total (B) above)

_____+ _____= $_____

$20 Optional Express Mail **Total Amount Due**

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 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 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 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.

X **Signature of Insured or Proxy**_____

Date_____ Phone_____

Payment Method ❑ Check (To IMG) ❑ Money Order (To IMG) ❑ Wire ❑ Mastercard ❑ Visa ❑ American Express ❑ Discover ❑ 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.

Card#_____Exp. Date_____

Cardholder Name _____

Signature_____

Cardholer Daytime Phone_____

Cardholder Billing Address_____

_____

IMG Producer Use Only

Producer# 51855 GA#_____

Name Insubuy, Inc.

Address 4200 Mapleshade Ln., Suite 200

City Plano Phone: (866) INSUBUY

State TX Zip Code 75093

insubuy.com