# Global Medical Insurance® APPLICATION

## Important Information

Global Medical Insurance offers two areas of coverage: Worldwide or Worldwide Excluding the U.S., Canada, China, Hong Kong, Japan, Macau, Singapore, and Taiwan. Either area provides coverage 24 hours a day, and you have the freedom to choose any doctor or hospital for treatment. Please note the risks and subjects of insurance under this plan are not intended or considered by the Company or IMG to be resident, located, or to be performed in any particular jurisdiction, and special eligibility requirements apply.

**Important Notice Regarding Patient Protection and Affordable Care Act (PPACA)** Global Medical Insurance is not subject to, and does not provide benefits required by PPACA. PPACA requires U.S. citizens and certain U.S. residents to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Tax 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. 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 your responsibility to determine if PPACA is applicable to you. For information on whether PPACA applies to you or whether you are eligible to purchase Global Medical Insurance, please see IMG's Frequently Asked Questions at imglobal.com/faq.

Also, this insurance is not subject to certain portability, access, renewal, or other requirements of the Health Insurance Portability and Accountability Act of 1996. Please read and review all of the eligibility requirements, coverage conditions, and pre-existing condition exclusions carefully before purchasing coverage. Marketing brochures and certificate wordings containing complete terms of coverage are available upon request. Please contact IMG or your independent insurance producer for details.

**FAILURE TO PROVIDE LEGIBLE AND COMPLETE INFORMATION MAY DELAY PROCESSING OF YOUR APPLICATION.**

**SECTION 1.** Please complete for all family members applying for coverage

| NAME<br>Please print your name below | HEIGHT | WEIGHT | DOB<br>*(MM/DD/YYYY)* | COUNTRY OF CITIZENSHIP | GOVERNMENT ISSUED ID NUMBER |
|---|---|---|---|---|---|
| **A.** Applicant (last, first, middle) ☐ Male ☐ Female | | | __/__/__ | | |
| **B.** Spouse (last, first, middle) ☐ Male ☐ Female | | | __/__/__ | | |
| **C.** First Child (below age 19 - last, first, middle) ☐ Male ☐ Female | | | __/__/__ | | |
| **D.** Second Child (below age 19 - last, first, middle) ☐ Male ☐ Female | | | __/__/__ | | |
| **E.** Third Child (below age 19 - last, first, middle) ☐ Male ☐ Female | | | __/__/__ | | |

**Residence Address** *(after this insurance becomes effective)*

| | | | |
|---|---|---|---|
| Street Address: | | | |
| City: | State: | Country: | Postal/Zip Code: |
| Telephone: | | Email: | |
| Fax: | **Is your expected length of residence outside the U.S. at least 6 of the next 12 months?** *(If a U.S. citizen and you answered "No," you are not eligible for coverage.)* ☐ Yes ☐ No | | |

**U.S. Citizens/U.S. Nationals:**

Date you did (or will) depart from the U.S.: __/__/__ *(MM/DD/YYYY)*

**Non-U.S. Citizens:**

If a non-U.S. citizen, do you or any other applicant have a green card or U.S. visa? If yes, please complete the following:

**a.** Type of visa _____ **b.** Issue date __/__/__ *(MM/DD/YYYY)*

**c.** Expiration date __/__/__ *(MM/DD/YYYY* **d.** Date of arrival in U.S. __/__/__ *(MM/DD/YYYY)*

Green Card ☐ Yes ☐ No

U.S. Visa ☐ Yes ☐ No

**Mailing Address** *(if different from above)*

| | | | |
|---|---|---|---|
| Street Address: | | | |
| City: | State: | Country: | Postal/Zip Code: |
| Telephone: | | Email: | |
| Fax: | **If either address above is in Florida, is the applicant currently located in Florida?** *(Determines applicable Premium tax and will not affect coverage)* ☐ Yes ☐ No | | |

☐ **I agree to the processing of my personal information to provide the services I have purchased, including to administer claims, and to receive member communications, in accordance with IMG's Privacy Policy.**

☐ **I agree to receive relevant information and other communications from IMG about insurance coverages and service options. I understand that I can withdraw my consent at any time.**

**SECTION 2a.** Please answer all questions for the applicant and for each family member applying for coverage

| | | If yes, show family member using letters from Section 1. |
|---|---|---|
| **1.** Are you or any other applicant currently disabled or unable to perform any activity of daily living? | ☐ Yes ☐ No | |
| **2.** Are you or any other applicant presently hospitalized, or scheduled for, in need of, or have been advised that you should have hospitalization or surgery? | ☐ Yes ☐ No | |
| **3.** Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy syndrome, Human Immunodeficiency Virus (HIV), or any other immune system disorder? | ☐ Yes ☐ No | |
| **4.** Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)? | ☐ Yes ☐ No | |
| **5.** Do you participate in professional sports, or are you a commercial pilot? | ☐ Yes ☐ No | |
| **If any individual answered YES to any of the above five questions, he or she does not qualify for this insurance. Thank you for your interest.** | | |
| **6.** Have you or any family member applying for coverage ever applied for or purchased insurance through IMG? (If yes: please provide certificate number, if any, and details.) By checking yes, you agree to the following: Do you acknowledge that you are applying for an entirely new certificate of coverage and not a renewal or reinstatement of any prior Global Medical Insurance® certificate(s) that you may have purchased through IMG in the past, and that, should IMG accept your new application, this would start a brand new coverage period under the terms, conditions, and provisions of the new insurance certificate (including, but not limited to, all eligibility requirements, pre-existing conditions and other exclusions, waiting periods, and benefit limits and sub-limits of the plan), and your new coverage will not qualify for any benefits of continuous coverage based upon your prior lapsed coverage?<br>Certificate number: _____ | ☐ Yes ☐ No | |
| **7.** Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please explain in Section 3. | ☐ Yes ☐ No | |
| **8.** Are you or any other applicant currently pregnant? If yes, please provide due date: __/__/__ *(MM/DD/YYYY)* | ☐ Yes ☐ No | |
| **9.** Have you or any other applicant had COVID-19/SARS-CoV-2?<br>**a)** Date diagnosed: __/__/__ *(MM/DD/YYYY)*<br>**b)** Date of last treatment: __/__/__ *(MM/DD/YYYY)*<br>**c)** Were you hospitalized? ☐ Yes ☐ No<br>**d)** Were you in intensive care? ☐ Yes ☐ No<br>**e)** Physician/hospital/clinic/health care provider name(s), address & telephone: _____<br>**f)** Condition(s)/diagnosis, prognosis, past and present course of teatment(s): _____ | ☐ Yes ☐ No | |
| **10.** Have you or any other applicant been fully vaccinated or received the most recent booster for COVID-19/SARS-CoV-2?<br>**a)** Date of final vaccination or most recent booster received: __/__/__ *(MM/DD/YYYY)*<br>**b)** Brand of vaccination received: _____ | ☐ Yes ☐ No | |
| **For questions 11-31:** Have you or any family member applying for coverage EVER experienced manifestation or symptoms of, suffered from, sought consultation for, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness, or other problem arising from, involving, or relating to any of the following: | | |
| **11.** Are you or any other applicant currently affiliated with a Mission Sending Organization (MSO)? By checking yes, you understand that this insurance is designed for persons residing outside of the U.S. for at least 6 out of the next 12 months and you certify that the above applicant(s) is/are affiliated with a Mission Sending Organization (MSO). I/We will be serving outside of the U.S. with a scheduled departure date from the U.S. within 30 days of the requested effective date. | ☐ Yes ☐ No | |
| **12.** Are you or any other applicant a Professional Marine Crew Member? By checking yes, you certify that you are a Professional Marine Crew Member who currently or usually works aboard a vessel as a full-time seagoing crew member. You expect to spend a significant period sailing outside of U.S. waters, and you do not qualify for adequate coverage under a U.S. domestic insurance plan.<br>If yes:<br>Do you reside onboard the vessel where you work? ☐ Yes ☐ No<br>Vessel Fax (if applicable): _____<br>Vessel Email (if applicable): _____<br>Current/Most recent Vessel Name: _____<br>Vessel Country of Registry: _____ | ☐ Yes ☐ No | |
| **13.** Heart, cardiac, cardiovascular, and/or circulatory, including, but not limited to congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 3, please complete the following:<br>**a)** Date of most recent blood pressure reading: __/__/__ *(MM/DD/YYYY)*<br>**b)** Most recent blood pressure reading: _____AS/_____DS<br>**c)** Medications taken (types and dosage): _____ | ☐ Yes ☐ No | |
| **14.** Blood, blood vessels, spleen, arteries, veins, or disorders of the blood, including but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol? | ☐ Yes ☐ No | |

| | | |
|---|---|---|
| **15.** Diabetes, hyperglycemia, or hypoglycemia? If yes to diabetes, in addition to Section 3, please complete the following:<br>**a)** Diabetic Type: I ☐ or II ☐<br>**b)** Date diagnosed: __/__/__ *(MM/DD/YYYY)*<br>**c)** Controlled by diet only? ☐ Yes ☐ No<br>**d)** Medications (types and dosage): _____<br>**e)** Date of most recent HbA1c Test: __/__/__ *(MM/DD/YYYY)*<br>**f)** Results of HbA1c Test (1-10): _____ | ☐ Yes ☐ No | |
| **16.** Asthma or allergies? If yes, in addition to providing explanation in Section 3, please specify which one and complete the following:<br>**a)** Date diagnosed: __/__/__ *(MM/DD/YYYY)*<br>**b)** Has hospitalization or emergency room treatment been required?<br>If yes, describe and list date(s): __/__/__ *(MM/DD/YYYY)*<br>**c)** Please list known triggers: _____<br>**d)** Medications (types and dosage): _____<br>**e)** Frequency of attacks: _____ | ☐ Yes ☐ No | |
| **17.** Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind? | ☐ Yes ☐ No | |
| **18.** Liver, pancreas, gall bladder, or endocrine disorders including but not limited to: pituitary, thyroid, or metabolic disorders, or obesity? | ☐ Yes ☐ No | |
| **19.** Kidney, urinary tract functions, kidney, or bladder stones or infections? | ☐ Yes ☐ No | |
| **20.** Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, or pleurisy pneumonia? | ☐ Yes ☐ No | |
| **21.** Mental, emotional, and/or nervous system disorders including but not limited to: psychosis, mental or behavioral disorders, ADD or ADHD, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders? | ☐ Yes ☐ No | |
| **22.** Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks? | ☐ Yes ☐ No | |
| **23.** Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis, or inflammation? | ☐ Yes ☐ No | |
| **24.** For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, and/or disorders of the reproductive system or of menstruation, including but not limited to: vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus, and hormone replacement therapy? | ☐ Yes ☐ No | |
| **25.** For male applicants, disorders of the reproductive system, including but not limited to: prostate or elevated PSA level, or erectile dysfunction? | ☐ Yes ☐ No | |
| **26.** Congenital, genetic, hereditary, or other birth condition or defect including but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity, or defect? | ☐ Yes ☐ No | |
| **27.** Digestive system, stomach, colon, rectum, or intestines, including but not limited to: esophageal regurgitation, gastritis, ulcers, Crohn's Disease, and/or diverticulitis? | ☐ Yes ☐ No | |
| **28.** Eyes, ears, nose, mouth, throat, or jaw, including but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ? | ☐ Yes ☐ No | |
| **29.** Do you or any family member applying for coverage currently use, or during the past five years, have used tobacco in any form? | ☐ Yes ☐ No | |
| **30.** Any other disease, medical problem, illness, injury, or condition of any kind not listed above? | ☐ Yes ☐ No | |
| **31.** During the last twelve (12) months, have you or any family member applying for coverage experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing, or treatment (including medications) for any medical, health, mental, physical, or nervous condition? If yes, please explain in Section 3. | ☐ Yes ☐ No | |
| **32.** Have you or any family member applying for coverage ever been rejected, cancelled, rated, or declined for coverage under any health, life, or disability insurance policy? If yes, please explain in Section 3. | ☐ Yes ☐ No | |
| **33.** During the last six (6) months, have you had comprehensive medical coverage?<br>If yes, present additional fields to collect information:<br>* Policy, certificate, or ID number: _____<br>* Private insurance or government plan name: _____<br>* Insurer or government entity providing the plan: _____<br>* Coverage start date: __/__/__ *(MM/DD/YYYY)*<br>* Coverage end date: __/__/__ *(MM/DD/YYYY)*<br>*** Include proof of coverage document(s):**<br>Sample acceptable documents:<br>* 1095 Forms<br>* Explanation of benefits or payment letters from prior insurer or government entity<br>* Coverage statements from prior insurer or government entity<br>* Payroll statements reflecting health insurance deductions<br>* Records of advance payments of the premium tax credit | ☐ Yes ☐ No | |

**SECTION 2b.** Please list all prescribed and over-the-counter medications, and any medical treatment in the last twelve months for the applicant and for each family member for whom it applies (use the corresponding letter(s) from Section 1). Please attach additional pages as necessary.

| Family Member *(Use letters from Section 1)* | Medications and Dosages | Conditions | Date(s) of Treatment *(MM/DD/YYYY)* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Family Member *(Use letters from Section 1)* | Surgeries | Date(s) of Treatment *(MM/DD/YYYY)* |
|---|---|---|
| | | |
| | | |
| | | |

**Family Practitioner's Details - The following information must be completed**

| | |
|---|---|
| Doctor's Name: | Telephone: |
| Address: | |
| Country: | Postal/Zip Code: |
| Date Last Seen: | Reason: |

**SECTION 3.** Medical Information

For any question answered "YES" in Section 2, please identify each family member for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address, and telephone number of the attending physician(s), hospital(s), clinic(s), and all other healthcare providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. ***Please attach additional pages as necessary.*** IMG and the Company reserve the right to request additional medical information prior to acceptance of application.

| Family Member *(Use letters from Section 1)* | Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s) | Physician/Hospital/Clinic/Healthcare Provider Name(s), Address & Telephone | Date(s) of Treatment *(MM/DD/YYYY)* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

If any family member applying for coverage has ever been rejected, cancelled, rated, or declined for coverage under any health, life, or disability insurance policy (see Question 30), please explain below.

**SUBSCRIPTION** (For coverage issued by SiriusPoint Specialty Insurance Corporation): I (we) hereby subscribe and apply to become beneficiaries of the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, Indiana, or its successor, for Global Medical Insurance® as offered by the Company on the date of its receipt hereof. I (we) understand and agree that: (i) no coverage will be effective until this Application has been duly accepted in writing by the Company, (ii) 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, (iii) IMG and the Company will rely on the accuracy and completeness of the infolrmation provided herein, (iv) any misrepresentation or omission contained herein will void the insurance certificate, 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 I (we) purposefully initiate and take advantage of the privilege of conducting business with the Company in Indiana, through IMG as its selected agent and administrator, and invoke the benefits and protections of its laws, and (vi) the contract of insurance represented by the Master Policy and evidenced by the Certificate of insurance shall 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 shall be in Marion County, Indiana, for which Applicant(s) hereby consent(s). I (we) agree that Indiana surplus lines law shall govern all rights and claims arising under this insurance, and trial of any dispute shall be by the court as fact finder, without a jury.

**ACKNOWLEDGEMENT** I (we) understand and agree that: (A)(i) marketing brochures and certificate wordings are available prior to application upon request, (ii) except for IMG, any insurance agent, broker or other producer (or their website), if any, involved with respect to the solicitation of this application is acting solely as my legal agent and representative and is representing my personal interests, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of, the Company or IMG, (iii) if IMG accepts my application WITH Creditable Coverage, then Global Medical Insurance defines "pre-existing conditions" as: any disease, Illness, Injury or medical condition, or symptoms linked to such disease, Illness, Injury or medical condition for which medical

advice, diagnoses or Treatment, including self-treatment, has been sought, recommended or received; or that I knew or reasonably should have known existed, whether or not I sought medical advice, diagnosis or Treatment), and covers them unless the pre-existing condition was not disclosed on my application or is the subject of special exclusion provided in a Rider to the Certificate of Insurance, (iv) if IMG accepts my application WITHOUT Creditable Coverage, then Global Medical Insurance defines "pre-existing conditions" as: any illness, Injury, 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 prior to the effective date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, treated, or disclosed to the Company or IMG prior to the effective date, and including any and all chronic, subsequent or recurring complications or consequences related thereto or resulting or arising therefrom, and coverage for pre-existing conditions varies by plan option (I should consult my plan option to verify coverage) (v) any disease, Illness, Injury or medical condition that is not disclosed on my application will never be covered under this certificate or renewal, (vi) the subjects of insurance applied for are not intended or considered by the Applicant(s), the Company or IMG to be resident, located, or to be performed in any particular jurisdiction, and (vii) 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. (viii) the Company, as carrier and underwriter of the plan, is solely liable for the coverages and benefits to be provided thereunder, and IMG acts solely as agent for the Company and has no direct or independent liability under the Master Policy or any Certificate of insurance. (B) This insurance is not subject to, and does not provide benefits required by, PPACA. On January 1, 2014, PPACA required U.S. citizens, U.S. nationals and certain U.S. residents 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, extend or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. It is an insured person's sole and exclusive responsibility to determine if PPACA is applicable to them, and the Company and IMG shall have no liability to any person whatsoever for their failure to obtain or maintain PPACA compliant insurance coverage. For information on whether PPACA applies to me or whether I am eligible to purchase Global Medical Insurance, I should see IMG's Frequently Asked Questions at imglobal.com/faq.

**CERTIFICATION** I (we) hereby certify, represent and warrant to IMG and the Company that: (i) I (we) have read the questions contained in this Application or they have been read to me (us), and I (we) understand them, (ii) my (our) responses to the questions are true, accurate, and complete in all respects as of the date hereof, and that I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto, (iii) I am (we are) currently in good health and, except for the conditions and other information disclosed herein, I (we) 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 condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance, and (iv) if this Application is signed as guardian or proxy of the Applicant, the signer warrants their authority and capacity to so act and 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 the Applicant.

**MEDICAL RELEASE** I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, healthcare 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 of any physical or mental condition, and/or employment status, to provide such information to IMG and/or the Company and my producer/broker involved in procurement of this application and/or insurance coverage.

**SATISFACTION GUARANTY/REVIEW PERIOD** It is understood I (we) will have 15 days from the effective date to review the insurance Certificate and all benefits, terms, conditions, limitations and exclusions of coverage. If not completely satisfied, I (we) may cancel this insurance by written request retroactive to the effective date and receive a full refund of premium.

**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.

*Global Medical Insurance is underwritten by SiriusPoint Specialty Insurance Corporation (publ) as applicable (the "Company"). It is distributed, managed, and administered, as agent for and on behalf of the Company, by International Medical Group® ("IMG®").*

| | |
|---|---|
| **X** _____ | Date: ____/____/_____ *(MM/DD/YYYY)* |
| **Signature of Applicant, Guardian, or Proxy** *(Relationship to Applicant if signing as Guardian or Proxy)* | |

| | |
|---|---|
| **X** _____ | |
| **Signature of of Spouse** | Date: ____/____/_____ *(MM/DD/YYYY)* |

**A guardian's signature is required for any applicant under the age of sixteen (16). See Directions for Completing the Application, Page 1, number 2, regarding Guardian or Proxy signatures.*

## Individual Term Life Insurance℠

Underwritten by International Medical Insurance Group via Alstead Re, a segregated cell company. Individual Term Life Insurance is only available at the time of application for, and with the purchase of, Global Medical Insurance®.

**SECTION 4.** Please indicate the name of each family member applying for Individual Term Life Insurance

| NAME | TERM LIFE UNIT ONE | TERM LIFE UNIT TWO |
|---|---|---|
| **A.** Applicant (last, first, middle) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **B.** Spouse (last, first, middle) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **C.** First Child (below age 19 - last, first, middle) | ☐ Yes ☐ No | NOT AVAILABLE |
| **D.** Second Child (below age 19 - last, first, middle) | ☐ Yes ☐ No | |
| **E.** Third Child (below age 19 - last, first, middle) | ☐ Yes ☐ No | |

**For each individual applying for life insurance, please indicate:**

| APPLICANT | PRIMARY BENEFICIARY AND CONTINGENT BENEFICIARY NAMES | RELATIONSHIP | % OF DEATH BENEFIT |
|---|---|---|---|
| **A.** | Primary beneficiary name: | | % |
| | Contingent beneficiary name: | | |
| **B.** | Primary beneficiary name: | | % |
| | Contingent beneficiary name: | | |
| **C.** | Primary beneficiary name: | | % |
| | Contingent beneficiary name: | | |
| **D.** | Primary beneficiary name: | | % |
| | Contingent beneficiary name: | | |
| **E.** | Primary beneficiary name: | | % |
| | Contingent beneficiary name: | | |

If a U.S. citizen, I (we) understand coverage for Individual Term Life Insurance will not be effective prior to the date of my (our) departure from the U.S.

| X _____ *(Initial here)* | X _____ *(Initial here)* | X _____ *(Initial here)* |
|---|---|---|
| Applicant | Spouse | For Covered Children |

If accepted for the Global Medical Insurance plan, I (we) understand that I (we) may qualify for Individual Term Life Insurance underwritten by International Medical Insurance Group via Alstead Re, a segregated cell company. I (we) do hereby apply to the Global Life Insurance Services Group Insurance Trust, Bank of Bermuda, Hamilton, Bermuda, for Individual Term Life Insurance as indicated above. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorizations, and warranties from the foregoing Application for Global Medical Insurance, and understand and agree that the terms, conditions, restrictions, and penalties thereof shall likewise apply hereto. I (we) also understand: (i) that in the event IMG does not accept this Application, its sole obligation is to return the premium to me (us), (ii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iii) that the Master Policy for Individual Term Life Insurance is issued in Bermuda and is governed by its laws.

| X _____ | __/__/__ | X _____ | __/__/__ |
|---|---|---|---|
| Signature of Applicant, Guardian, or Proxy | Date *(MM/DD/YYYY)* | Signature of Spouse | Date *(MM/DD/YYYY)* |

## SECTION 5. Deductible selection and premium calculation

**Note:** Plan option, deductible selection, payment mode, and area of coverage must be the same for all family members.

Check one Plan Option: ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

Check one Deductible: ☐ $100 *(Platinum only)* ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 *(Gold and Platinum only)*

Check one Payment Mode: ☐ Annual = 1.00 ☐ Semi-Annual = 0.55 ☐ Quarterly = 0.28 ☐ Monthly = 0.10

Check one Area of Coverage: ☐ Worldwide ☐ Worldwide excluding the U.S., Canada, China, Hong Kong, Japan, Macau, Singapore, and Taiwan

**PREMIUM CALCULATION** (Applications without payment of premium will not be approved)

*Except for Global Group, IMG will not accept wires for semi-annual, quarterly, or monthly payment modes. Alternative payment modes are only accepted with pre-authorization to debit your credit card on the due date(s) of your future premium installment(s). Annual premiums may be paid by wire transfer, eCheck (available online), or by credit card. The insurance certificate can be express mailed for an optional $25 fee.*

Enter the ***annual*** Global Medical Insurance premium for each family member that corresponds to their age, gender, and deductible.

***Application cannot be processed unless this section is completed.***

| | |
|---|---|
| Primary Applicant | $ _____ |
| Spouse | $ _____ |
| 1st Child | $ _____ |
| 2nd Child | $ _____ |
| 3rd Child | $ _____ |
| **GMI Subtotal** | **$** _____ |

**Optional Benefits:**

Terrorism Rider: ☐
*(Platinum plan option only. Check the box and enter 1.25 if applicable)* — **X** _____

**GMI Subtotal** = — **A$** _____

Term Life Rider:
Individual Term Life Unit One $240 X_____ = *# of adults applying* — **B$** _____

Individual Term Life Unit Two $180 X_____ = *# of adults applying* — **C$** _____

Term Life Unit One - Child $100 X_____ = *# of children applying* — **D$** _____

Dental & Vision Rider:
$570 *(worldwide)* or $460 *(worldwide excluding)* X_____ = *# of family members applying*
*(Applies to all plans except Platinum)* — **E$** _____

Optional Sports Rider:
$250 X_____ = *# of family members applying*
*(Applies only to Gold and Platinum plan options)* — **F$** _____

Mobile Device Protection Rider:
$146 X_____ = *# of family members applying* — **G$** _____

Subtotal (A+B+C+D+E+F+G) = — **H$** _____

$ _____ X _____ + $ _____ = — **I$** _____
*Subtotal H* *Modal Factor* *Optional Express Mail**

**Modal Factors: Annual=1.00 Semi-Annual=.55 Quarterly=.28 Monthly=.10** — **Premium Amount Due**

**Note:** *Choosing the semi-annual payment option (modal payment factor .55) results in total payments of 110% of the annual premium, choosing the quarterly payment option (modal payment factor .28) results in total payments of 112% of the annual premium, and choosing the monthly payment option (modal payment factor .10) results in total payments of 120% of the annual premium.*

*Optional $85 express mail: Certificate(s) will be express mailed to you after approval

IF YOU CHOOSE EXPRESS MAIL: Please select the address where you would like your Certificate express mailed (as indicated in Section 1)

☐ Residence address ☐ Mailing address

☐ Other (no P.O. boxes please)

☐ **I WOULD PREFER TO RECEIVE AN ELECTRONIC CERTIFICATE**

Email:

## METHOD OF PAYMENT

| | | |
|---|---|---|
| ☐ Wire *(annual only)* | ☐ MasterCard | ☐ Visa |
| ☐ American Express | ☐ Discover | ☐ JCB |

☐ Global Group *(complete additional insert)*
Group Name: _____

eCheck (ACH) available online
*(Authorized signature required for credit card payments)*

For wire transfer information, please contact IMG. All payments must be made in U.S. dollars and drawn on a U.S. bank at the time application for coverage is made. If paying by credit card, I authorize IMG to debit my credit card for the total amount due. In the event that I have chosen to pay premiums semi-annually, quarterly, or monthly, **I hereby elect to pre-authorize future credit card payment installments for the balance of the policy period and for renewals, and hereby request and authorize IMG to charge my credit card periodically as payment installments become due for premiums and renewal premiums INCLUDING AS DESCRIBED BELOW FOR AUTOMATIC RENEWALS. This authorization will remain in effect until revoked by me in writing, and until IMG actually receives the notice of revocation.** Coverage purchased by credit card is subject to validation and acceptance by the credit card company. You understand that the amount we charge for premium may be more than the amount on the rate sheet based on your medical history and the underwriting process and you authorize such payment amount.

| | |
|---|---|
| Credit Card #: | |
| Exp. Date: __/__ *(MM/YYYY)* | *(Cannot be earlier than last premium installment due date)* |
| Authorized Signature: **X** _____ | |
| Name as it Appears on Card: | |
| Daytime Phone #: | |
| Billing Address: | |
| | |
| **REQUESTED EFFECTIVE DATE:** __/__/__ *(MM/DD/YYYY)* | |

*(Must be within 30 days after signature. Coverage will in no event be effective until approved.)*

## SECTION 6. Renewal Contact Information

Please specify the best way to contact you at renewal:

☐ Mail *(please provide address):*

☐ Fax *(please provide fax number):*

☐ Email *(please provide email address):*

**Automatic Renewal Notice**
For your convenience, we will notify you of your renewal premium in advance of your renewal date and automatically renew your plan, thereby preventing any accidental break in coverage at renewal - unless, of course, you are no longer eligible or we hear from you to the contrary before renewal.

## SECTION 7. Insurance Producer Use Only

| | | |
|---|---|---|
| IMG Producer Number #: 223947 | Producer Name: AANDF INSURANCE SERVICES | |
| Company Name: | | |
| Address: 13697 LAVENDER MIST LN | | |
| City: CENTREVILLE | State: VA | Postal/Zip Code: 20120 |
| Telephone: 703-280-4949 | Fax: | |
| Email: anfins@gmail.com | Website: | |
| Producer Signature: X _____ | GA #: | |

**Send by one of the following secure methods:**

**Secure Message Center:** www.imglobal.com/secure-message-center
**Fax:** +1.317.655.4505

**For other inquiries, contact IMG by:**

**Phone:** +1.317.655.4500
**Email:** insurance@imglobal.com

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