



**PART D. Claims Reimbursement- Alternate Payee Request-** Must be completed by Parent or Guardian if insured is under 18 years of age. An alternate payee may be elected to receive payment by draft (in USD only), when requested payment is to someone other than insured or provider of medical service(s).

Print name of requested alternate payee:

Print mailing address for alternate payee draft,  
if requesting a different location than the insured:

**Wire Transfer Request-** If payment is to be sent by wire transfer, please indicate below by completing full details of bank and/or transfer information (Wire cannot be honored if below is incomplete or inaccurate. If no currency is requested, claims will be settled in USD)

Name of account holder (how it appears on account):

Bank Account (U.S.) or IBAN (non-U.S.):

Sort or Swift Code (non-U.S. Bank):

Routing Number (U.S. bank):

Requested currency for transfer:

Bank name:

Bank phone number:

Bank address:

**PART E. Authorization – To be completed by the Claimant for all claims.**

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge.

I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to International Medical Group®, Inc. or any agent or administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed.

Print Name \_\_\_\_\_

Signature of Insured/ Guardian \_\_\_\_\_ Date \_\_\_\_\_  
day/ mo/ yr

**AUTHORIZATION:** I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

Signature of the Insured/ Guardian \_\_\_\_\_ Date \_\_\_\_\_  
day/ mo/ yr

Form IMG- 37

Updated 11/06

**Forward Claims to:**

**International Medical Group®, Inc.**  
P.O. Box 88500  
Indianapolis, IN 46208-0500  
Outside U.S. & Canada: 317.655.4500  
Inside U.S. & Canada: 800.628.4664  
Fax: 317.655.4505

OR

**IMG Europe Ltd.**  
36-38 Church Road, Burgess Hill  
West Sussex, RH15 9AE  
United Kingdom  
Phone: +44 (0) 1444 46 55 55  
Fax: +44 (0) 1444 46 55 50  
Email: [customercare@imglobal.com](mailto:customercare@imglobal.com)