International Marine Medical Insurance SM (IMMI)

Application for Group Insurance

Please print legibly and complete ALL sections of this application

1 PROSPECTIVE PARTICIPATING ORGANIZATION ("APPLICANT")

Full Legal Name:	Vessel Name:	
Address:		
City:	State:	Postal/Zip Code:
Country:	EIN/ TIN:	Government Issued ID Number:
At the time of this application, are any applicants currently located in the state of New York? ☐ Yes ☐ No *(If yes, then the purchase of this plan is not available)*		
Authorized Representative:		
Telephone Number:	Fax Number:	Requested Effective Date: ___/___/___ *(MM/DD/YYYY)*
Fulfillment Option: ☐ Email ☐ Mail	Communications should be sent via email to:	
MyIMG Group Administrator User ID: *(6 or more characters)*		Amount of Premium Deposit: $

☐ I am an authorized representative of the group members and the group members agree to the processing of their personal information to provide the services they have purchased, including to administer claims, and to receive member communications, in accordance with IMG's Privacy Policy

☐ I am an authorized representative of the group members and the group members agree to receive relevant information and other communications from IMG about insurance coverages and service options. The group members understand that they can withdraw consent at any time.

2 EMPLOYEE WAITING PERIOD FOR FUTURE EMPLOYEES

First of the Coverage Month Following _____ Days of Full-Time Employment
(number)

3 EMPLOYER CONTRIBUTION

_____ % of Employee Premium	_____ % of Dependent Premium

4 ELIGIBLE EMPLOYEES *(Organization must have at least 2 employees enrolled to receive and maintain coverage under the contract)*

Number of Employees:	Number of Eligible Employees:	Number of Employees Applying for Coverage:

5 CHOOSE A PLAN

☐ IMMI	☐ IMMI Gold	☐ IMMI Platinum
Medical Deductible: $	Family Deductible Limit (2x or 3x):	Period of Coverage Maximum: $

6 CHOOSE YOUR OPTIONS

Optional Sports Expansion Coverage: ☐ Yes ☐ No *(Included with IMMI Gold)*

Dental: ☐ Yes ☐ No	Life & AD&D:* ☐ Yes ☐ No

Daily Hospital Indemnity: ☐ Yes ☐ No *(Life insurance required in order to purchase this benefit)*

International Marine Medical Insurance is a fully insured group benefit plan. The medical portion of the benefit plan is underwritten by Crum & Forster SPC, a member of the Crum & Forster Group of Companies and is available to members of the Fairmont Specialty Trust, LTD, c/o ITA Global Trust LTD, Camana Bay, Grand Cayman.

**The Life portion of the benefit plan is underwritten by International Medical Insurance Group via Alstead Re, a segregated cell company distributed, managed and administered, as agent for IMG, by International Medical Group®, Inc. (IMG®).*

Send by one of the following secure methods:

Secure Message Center: www.imglobal.com/secure-message-center
Mail: International Medical Group®
2960 North Meridian Street, Ste. 300,
Indianapolis, IN 46208-0509 USA
Fax: +1.317.655.4505

For other inquiries, contact IMG by:

Phone: +1.317.655.4500
Email: insurance@imglobal.com

7 MODE AND METHOD OF PAYMENT *Name of Participating Organization (The Employer) Applying for Group Coverage*

Mode of Payment:	**Select One**	☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual
Method of Payment:	**Select One**	☐ Check ☐ Money Order ☐ e-Check ☐ American Express ☐ Visa ☐ MasterCard ☐ Discover ☐ Wire Transfer/ACH
If Paying by Credit Card:	**Select One**	☐ I want the selected credit card to be debited ONLY for the 1st premium payment, based on the selected Mode of Payment. ☐ Until further notice, I want the selected credit card to be debited for ALL premium payments (current and future), based on the selected Mode of Payment. I have the right to change the Method of Payment at any time.

- Checks and Money Orders should be made payable to International Medical Group (IMG).
- All payments must be made in U.S. dollars and drawn on a U.S. bank at the time of application for coverage to be bound.
- If paying by credit card, I authorize IMG to debit the above indicated credit card account for the total amount due, based on the selected Mode of Payment.
- This Authorization will remain in effect until notification is received from the Sponsoring Organization (the Employer).

CREDIT CARD AUTHORIZATION

Credit Card Number:

Expiration Date:

Name as it appears on card:

Billing address: _____

Phone Number:

Email Address:

Authorized Signature on card:

E-CHECK PAYMENT INFORMATION

Name of Participating Organization *(the Employer)* applying for group coverage: _____

Please include the following **e-Check information** on the account:

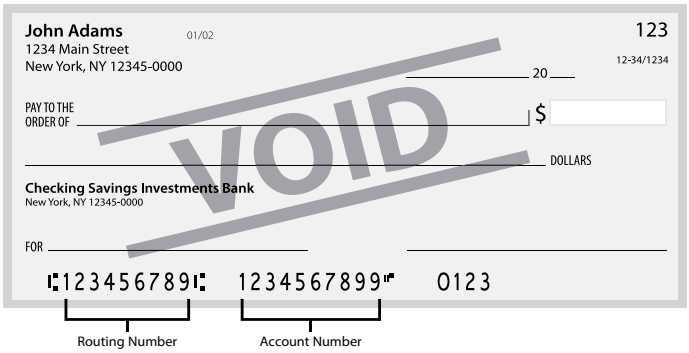
Name(s) on Account:

Account Number:

Routing Number:

Select One ☐ Commercial Checking ☐ Consumer Checking ☐ Consumer Savings

All **e-Check** payments must be made in U.S or Canadian dollars.
Please attach VOID check or DEPOSIT SLIP with this form.



attach your void check here

By supplying account information, Applicant wishes 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 Applicant has the card or account holder's authorization to use the account and, if not, will take full responsibility for the payment and any changes accruing to it. By submitting the signed application, the Applicant agrees to pay via credit card or applicable account the premium amount owed and have read and agree to all terms, conditions, and other statements in this application. The Applicant hereby authorizes IMG to debit their payment type for the total amount due. In the event that the Applicant has chosen to pay premiums semi-annually, quarterly, or monthly, they 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 the credit card periodically as payment installments become due for premiums and renewal premiums. The Applicant hereby requests and authorizes IMG to secure premium payments with the selected check information. This authorization will remain in effect until revoked by the Applicant 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. The Applicant understands that they will be given advance notice of the renewal premiums and that they may vary each year.

Printed Name:	Authorized Signature: **X** _____ *(Initial here)*
Title (if applicable):	
Other Comments:	

NOTE: When sending payment information, health information, and other documents and data regarding your confidential personal information, please send by secure means only.

8 AUTHORIZATION

SUBSCRIPTION
I hereby apply to be a Plan Participant of Fairmont Specialty Trust (the "trust") and to participate in the insurance coverage extended by certain underwriters at HDI Global Specialty ("the insurers") to Plan Participants under the trust (the "coverage"). I understand that the coverage is not a general health insurance product, but is intended for use in the event of a sudden and unexpected event while traveling outside my home country. I understand that the coverage extended to me will terminate upon my return to my home country unless I qualify for a benefit period or home country coverage. I understand that I may obtain full details of the coverage by requesting a copy of the master policy from the plan manager. I understand that the liability of the Insurers as underwriters of the coverage is as provided in the master policy. By acceptance of coverage and/or submission of any claim for benefits, the Plan Participant ratifies the authority of the signer to so act and bind the Plan Participant. The Plan Participant undertakes to make all premium payments as they fall due in respect of the coverage extended to them. The trustee shall not be responsible for the administration of such payments. If the Plan Participant fails to make any premium payment due in respect of the coverage extended to them, subject to the discretion of the insurance company, such coverage will lapse. The Plan Participant hereby confirms the accuracy of all information validity of all representations and warranties provided to the trustee in connection with its participation in the Plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this subscription agreement, (together "representations & warranties"). The Plan Participant acknowledges that certain of such information will be relied upon by the Insurers as providers of the coverage and that any inaccuracy therein may result in the invalidity of such coverage as it relates to the Plan Participant, the loss of coverage and all monies paid in relation thereto. The Plan Participant hereby undertakes to inform the trustee of any change to any of matter that forms the subject of any of the representation & warranties. The Plan Participant hereby undertakes to indemnify and hold harmless the trustee against any loss of damage (including attorney's fees) occasioned by any inaccuracy in any representation & warranty or failure to advise the trustee of any change in any matter that forms the subject of any of the representation & warranties. The Plan Participant agrees that the trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by the Plan Participant and the Plan Participant hereby undertakes to indemnify and hold harmless the trustee against any loss or damage (including attorney's fees) occasioned by the trustee acting in accordance with any such instruction. Payments under the terms of the coverage shall be paid by the insurers to the Plan Participant or directly to a provider if assignment of benefits has been authorized. The trustee shall not be responsible for the administration of such payments. I confirm that I have satisfied myself that the coverage is appropriate for me and that I meet the eligibility criteria.

APPLICATION
The Participating Organization, by its authorized representative, hereby applies for International Marine Medical Insurance (IMMI) insurance coverage as underwritten and offered by the Company and administered by the Company's authorized representative and plan administrator, International Medical Group, Inc. (IMG). The Applicant understands and agrees that : (i) the Applicant 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, (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, and (iii) 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 and any and all claims and benefits thereunder will be forfeited and waived. Rates are based on your submitted census. International Medical Group reserves the right to adjust the rates from audit date back to effective date if any of the following changes occur or are discovered after the date of the proposal: Enrollment +/- 10%, Average Contract Size +/- 10%, Area Factor +/- 7.5%, Age/Sex Factor +/- 10%, Any Material Changes, Less than 100% of all eligible employees enroll in an employer sponsored plan, Less than 80% of all benefit eligible employees (including spousal waivers) enroll with International Medical Group. Please also note that plans do not include a provision for 4Q deductible carryover or deductible credit from prior carrier.

ACKNOWLEDGEMENT
The Applicant understands and agrees that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of the applicant(s) and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) this insurance contains a number of exclusions from coverage, including an exclusion for pre-existing conditions, in order to review all coverage details a complete copy of the insurance contract, including all exclusions, may be provided upon request, (iii) the subjects of insurance applied for are not intended or considered by the Applicant, 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, (v) the Applicants also agree it is their responsibility to provide IMG with true, accurate and complete email 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.

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 Applicant hereby certifies, represents and warrants that: (i) the Applicant has read the foregoing statements and any marketing materials and a sample insurance contract that were made available upon request and prior to the application or that they have been read to the Applicant, and the Applicant understands them, (ii) the Applicant is eligible to participate in the insurance program applied for, (iii) if signed as the legal representative of the Applicant, the signer warrants their authority of the signer to so at and bind the Applicant, and (iv) subject to Company's acceptance of this application and payment of the total amount due, coverage will begin at 12:01 a.m. on the approved effective date. The Applicant understand that if premium is returned unpaid for any reason, coverage becomes null and void.

IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)
This insurance is intended for Participating Organizations with Employees on expatriate status (Employees who have a good faith belief that they will reside outside of their Home Country for at least six (6) months during a plan year) and their Spouses and Dependents. This insurance is provided by Crum & Forster SPC (the Company), located in the Cayman Islands that is regulated by a foreign government, and is considered to be Minimum Essential Coverage under the United States Patient Protection and Affordable Care Act (PPACA) for each month when the Employee is outside of the United States for at least one (1) day of that month or when the Employee is physically present in the U.S. for an entire month if the coverage provides health benefits within the United States while the individual is on expatriate status. 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 Employee's responsibility to determine the insurance requirements that are applicable to him/her and the Company and IMG shall have no liability whatsoever, including for any penalties that the Employee may incur, for 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 email 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 Applicant acknowledges and agrees that IMG will automatically renew your coverage by enrolling your group into the then-current IMMI group plan whose terms shall be those set forth in the then-current and in-force Certificate of Insurance as of the date of such auto-renewal and that IMG shall do so each year on your certificate anniversary (an "Automatic Renewal") unless an authorized representative of your group affirmatively communicates an intention to non-renew at least 30 days prior to group anniversary date or as otherwise set forth in the Certificate of Insurance. You will receive an automatic renewal notice prior to our anniversary date.

Authorized Representative Signature: X _____ *(Initial here)*	Date: ___/___/___ *(MM/DD/YYYY)*
Printed Name:	Title/Position:
Producer Signature: X _____ *(Initial here)*	Date: ___/___/___ *(MM/DD/YYYY)*
Printed Name:	Producer Number: