MP+International
Application for Group Insurance

Please print legibly and complete ALL sections of this application.

PARTICIPATING ORGANIZATION ("APPLICANT")

Full Legal Name:	Doing Business As:	
Address:		
City:	State:	Postal/Zip Code:
Country:	EIN/ TIN:	Government Issued ID Number:
Authorized Representative:		
Telephone Number:	Fax Number:	Requested Effective Date: ___/___/___ *(MM/DD/YYYY)*
Fulfillment Option: ❑ Email ❑ Mail	Communications should be sent via E-mail to:	
My*IMG* 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.

EMPLOYEE WAITING PERIOD FOR FUTURE EMPLOYEES

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

EMPLOYER CONTRIBUTION

_____ % of Employee Premium	_____ % of Dependent Premium

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:

REQUESTED BENEFITS

Plan Option: ❑ Standard Plan ❑ Alternative Plan		
Medical Deductible: $	Family Deductible Limit (2x or 3x):	Lifetime Maximum: $
Dental: ❑ Yes ❑ No	Dental Option: ❑ 1 ❑ 2 ❑ 3	
Life & AD&D: ❑ Yes ❑ No	Life & AD&D Amount: $	
Daily Hospital Indemnity: ❑ Yes ❑ No	Teleconsultation ❑	
Dependent Life Insurance: ❑ Yes ❑ No *(Life insurance required in order to purchase this benefit)*		

REQUESTED ASSISTANCE SERVICES

❑ Medical and Security Evacuation Services ❑ Travel Intelligence Portal ❑ Remote Mental Health Services

Non-Insurance Assistance Services Acknowledgment
The Applicants, by and through its undersigning authorized agent, acknowledge that, due to the relationship between the Applicants and IMG, that individual Members of the Group may be eligible for other non-insurance services, such as travel assistance services, offered by IMG. The Applicants hereby acknowledge that these services are not insurance, are not included with the Insurance premium, and are only available for a separate fee. Further, Applicants acknowledge that the services are limited to those services contracted for pursuant to a Master Services Agreement ("MSA"). The terms of the MSA have been made available for review and agreement by the Applicants prior to signing this acknowledgment.

MP+International group insurance is underwritten and offered by:
Sirius International Insurance Corporation, and will be deemed issued and made in Hamilton, Bermuda, governed by Bermuda law, with sole and exclusive jurisdiction and venue for any legal proceeding relating to this insurance in Hamilton, Bermuda.

REQUESTED ASSISTANCE SERVICES

SUBSCRIPTION As a condition-precedent to applying for this insurance, the undersigned, on behalf and with the authority from the Sponsoring Organization and its individual Participants ("Applicant," "You" or "Your"), represents and warrants they are the authorized agent of the Applicant and hereby applies and subscribes, for and on behalf of each individual enrolled, to the Conyers Trust Company (Bermuda) Limited, Richmond House, 12 Par-la-Ville Road Hamilton HM 08, Bermuda, or its successors, for the insurance coverage requested above and as underwritten and offered by Sirius International Insurance Corporation on the date of its receipt hereof, and as administered by the Company's authorized representative and Policy Manager, International Medical Group, Inc (IMG).

APPLICATION The Participating Organization, by its authorized representative, hereby applies for MP+ International 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 understand 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 Contact 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 not 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 any illness, injury, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment for which: medical advice, diagnosis, care or Treatment was recommended or received at any time during the six (6) months prior to the effective date or a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Insured person's Initial Effective Date, (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 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.

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 not subject to, and does not provide benefits required by, PPACA. 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.

Authorized Representative Signature: X _____	Date: ___/___/___ (MM/DD/YYYY)
Printed Name:	Title/Position:

Producer Signature: X _____	Date: ___/___/___ (MM/DD/YYYY)
Printed Name:	

Send by one of the following secure methods:
Secure Message Center: www.imglobal.com/secure-message-center
Encrypted Email: insurance@imglobal.com
Fax: +1.317.655.4505

Mail: International Medical Group, Inc., 2960 North Meridian Street, Ste 300, Indianapolis, IN 46208-0509 USA
For Other Inquiries, Call: +1.317.655.4500