MP+ International
Application for Group Insurance

Insurance Company ("Company") MP+ group insurance is underwritten and offered by:
Sirius International Insurance Corporation (publ), 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.

PROSPECTIVE 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: *(month/day/year)*
Fulfillment Option: ❑ Email ❑ Mail	Communications should be sent via E-mail to:	
MyIMG Group Administrator User ID *(6 or more characters)*:		Amount of Premium Deposit: $

EMPLOYEE WAITING PERIOD FOR FUTURE EMPLOYEES
First of the Coverage Month Following _____ Days of Full-Time Employment *(number)*

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		
Dependent Life Insurance: ❑ Yes ❑ No *(Life insurance required in order to purchase this benefit)*	Emergency Medical Evacuation: ❑ Yes ❑ No	

AUTHORIZATION

APPLICATION The Participating Organization (Applicant), by its authorized representative, hereby applies for MP+ 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.

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, and a complete copy of the insurance contract, including all exclusions, has been made available for review and agreement by the Applicant prior to this insurance becoming effective, (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.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) This insurance is intended for Participating Organizations with members on expatriate status (members who have a good faith belief that they will reside outside of their Home Country for at least six months during a plan year) and their Spouses and Dependents. This insurance is regulated by a foreign government, and is considered to be Minimum Essential Coverage under the U.S. Patient Protection and Affordable Care Act (PPACA) for each month when the member (i) is outside of the U.S. for at least one day of that month or (ii) is physically present in the U.S. for an entire month if the coverage provides health benefits within the U.S. while the member 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 Applicant's responsibility to determine the insurance requirements that are applicable to it and the Company and IMG shall have no liability whatsoever, including for any penalties that Applicant or any of its members may incur, for failure to obtain coverage required by any applicable law, including without limitation PPACA.

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 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 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 understands that if premium is returned unpaid for any reason, coverage becomes null and void.

Authorized Representative Signature:	Date: *(month/day/year)*
Printed Name:	Title/Position:
Producer Signature:	Date: *(month/day/year)*
Printed Name:	

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