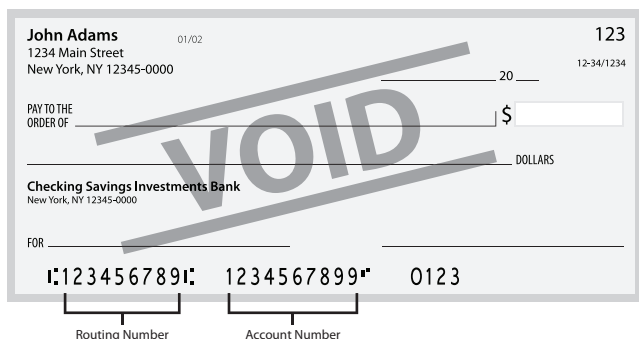


MP+International® Group Mode and Method of Payment



INTERNATIONAL MEDICAL GROUP

Name of Sponsoring Organization (The Employer) Applying for Group Coverage	
Name of Sponsoring Organization (the Employer) applying for group coverage:	
Mode of Payment: (select only one)	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual
Method of Payment: (select only one)	<input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Wire Transfer <input type="checkbox"/> e-Check <input type="checkbox"/> American Express <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> JCB
If Paying by Credit Card: (select only one)	
<input type="checkbox"/> I want the selected credit card to be debited ONLY for the 1st premium payment, based on the selected Mode of Payment.	<input type="checkbox"/> 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.
<ul style="list-style-type: none"> • 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	e-Check Payment Information
Credit Card Number:	Name of Sponsoring Organization (the Employer) applying for group coverage:
Expiration date:	Please include the following eCheck Information on the account:
Name as it appears on card:	Name(s) on account:
Billing address:	Account number:
Phone number/e-mail address:	Routing number:
Authorized signature on card:	Select One <input type="checkbox"/> Commercial Checking <input type="checkbox"/> Consumer Checking <input type="checkbox"/> Consumer Savings



tape your void check here

All e-Check payments must be made in U.S. or Canadian dollars. I hereby request and authorize IMG to secure premium payments with the selected check information. This authorization will remain in effect until revoked by me in writing and until IMG actually receives notice. Please attach VOID check or DEPOSIT SLIP with this form.

Authorized signature:
Printed name :
Title (if applicable):
Other comments: