

Sports Registration Cancellation/ Interruption Claim Form



Please complete ALL SECTIONS (front and back) of this application before submitting.
 Claims may be emailed to: itravelclaims@imglobal.com
 Additional options for submission are listed at the bottom of this form.

To report a loss, return the required documentation, along with your original, signed claim form to IMG.
 A delay in the processing of the claim will occur if unacceptable proof of loss or an incomplete claim form is submitted. Proof of claim must be submitted within 90 days of the date of loss. IMG reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.

The following documentation will initially be required to begin processing of your claim:

- The fully completed claim form, signed and dated
- The purchase confirmation showing amount paid for sports registration
- Proof of payment for the sports registration
Examples: credit card statement, cancelled check, etc.

If sports registration was cancelled or interrupted due to sickness, injury, or death, include the medical documentation including but not limited to:

- Attending physician's statement *(completed by a physician)*
- Copy of death certificate and obituary *(if applicable)*
- Proof of relationship *(if cancellation is due to the illness, injury, or death of a family member)*

If sports registration was cancelled or interrupted due to other causes, include the additional documents to show proof of loss due to any of the "Other Covered Reasons" identified in the insurance contract:

- Dated notice of jury duty or copy of summons to appear in court as a witness
- Letter from employer outlining dates of hire and termination, attesting to permanent transfer of employment
- Copy of quarantine order from government health authority
- Copy of military orders and documentation from commanding officer verifying call to emergency duty or revocation of previously granted leave
- Letter from transportation authority attesting to hijacking incident
- Fire marshal or insurance company report attesting to the fact the primary residence is uninhabitable

PRIMARY CLAIMANT INFORMATION

Insured's Name: <i>(Last, First, Middle)</i>		Policy Number:
Mailing Address:		
Email Address:	Cell Phone Number: <i>(with area code)</i>	

If you are a guardian or parent claiming on behalf of an insured aged 17 or under, your contact details must match those used at the time of purchasing this policy.

Please note: by providing an email address and cell phone number on this form, you agree to electronic communications (including emails and SMS) about any claims that you have submitted.

PART 1. GENERAL INFORMATION

1. Full Name of Claimant: <i>(for additional claimants, please attach additional sheets)</i>		Date of Birth: ___/___/___ <i>(MM/DD/YYYY)</i>
Policy Number:	Relationship to Insured:	
2. Full Name of Claimant:		Date of Birth: ___/___/___ <i>(MM/DD/YYYY)</i>
Policy Number:	Relationship to Insured:	
3. Full Name of Claimant:		Date of Birth: ___/___/___ <i>(MM/DD/YYYY)</i>
Policy Number:	Relationship to Insured:	
4. Full Name of Claimant:		Date of Birth: ___/___/___ <i>(MM/DD/YYYY)</i>
Policy Number:	Relationship to Insured:	
Date Sports Registration Purchased: ___/___/___ <i>(MM/DD/YYYY)</i>	Sports Registration Start Date: ___/___/___ <i>(MM/DD/YYYY)</i>	
Sports Registration End Date: ___/___/___ <i>(MM/DD/YYYY)</i>	Actual End Date: ___/___/___ <i>(MM/DD/YYYY)</i>	
Please check the box for benefits requested:	<input type="checkbox"/> Cancellation	<input type="checkbox"/> Interruption
<ul style="list-style-type: none"> If the cancellation and/or interruption is due to sickness, injury, or death, please complete the entire claim form. If the cancellation and/or interruption is due to non-medical reason(s), please complete parts 2 and 4. 		

PART 2. EXPLANATION OF LOSS

Describe in detail what occurred:		
Date cancelled/interrupted: ___/___/___ <i>(MM/DD/YYYY)</i>	Total paid for sports registration prior to cancellation: <i>(do not include travel insurance premium)</i>	Total paid per insured prior to cancellation: <i>(USD)</i>

Proof of payment is required for all losses claimed. Claims cannot be processed without proof of loss.

PART 3. MEDICAL INFORMATION - Complete for cancellation/interruption due to sickness, injury, or death

Patient's Name:	Relationship to Insured:	Date Symptoms First Noticed: __/__/__ (MM/DD/YYYY)
Nature of Illness:		Date of First Consultation: __/__/__ (MM/DD/YYYY)
Describe onset, diagnosis, and treatment:		
For injury, describe injury:		Date of First Consultation: __/__/__ (MM/DD/YYYY)
How and where did the accident occur:		
If hospitalized, hospital name, website, and address:		Date of Confinement: __/__/__ (MM/DD/YYYY)
		From:
		To:
Name and address of treating physician:		Telephone Number (with area code)
		Fax Number (with area code)

PART 4. OTHER COVERAGE

Do you have any other insurance or coverage related to the loss (e.g. Domestic Health Insurance, Travel, Homeowners, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any other travel insurance coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you report the loss to any other insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes, which company:

Name of Company:	Policy/Certificate Number:	Telephone Number: (with area code)	Website:
1. _____ Address: _____	_____	_____	_____
2. _____ Address: _____	_____	_____	_____
3. _____ Address: _____	_____	_____	_____
<i>(Please attach a separate sheet if necessary)</i>			

PART 5. CERTIFICATE OF MEDICAL CONDITION/MEDICAL PROVIDER'S STATEMENT

Patient's Name:	Date of Birth: ___/___/___ (MM/DD/YYYY)
Insured's Name:	Patient's Relationship to Insured:
Policy Number:	Policy Purchase Date: ___/___/___ (MM/DD/YYYY)

ATTENDING PHYSICIAN'S STATEMENT... MUST BE COMPLETED AND SIGNED BY THE PHYSICIAN

1. Diagnosis: Nature of sickness/injury causing cancellation/interruption: *(please be specific)*

a. Primary diagnosis of ICD-9 code: _____

b. Secondary diagnosis of ICD-9 code: _____

2. When did symptoms of sickness or injury first occur? ___/___/___ (MM/DD/YYYY)

3. When did the patient first consult you for this condition? ___/___/___ (MM/DD/YYYY)

4. If patient was referred from another provider, name of provider, address, and telephone number: *(with area code)*

5. Name, address, and telephone number of other medical personnel involved:

6. Was there any medical condition, injury, illness, or sickness that would interfere with the insured's ability to participate?

Yes
 No

If yes, please explain and indicate when patient was determined not to be medically fit to participate: _____

7. List all dates of treatment and services for this condition

Date of Services: ___/___/___ (MM/DD/YYYY) <i>(Please attach a separate sheet if necessary)</i>	Describe the Condition/Treatment:
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8. Has the patient been hospitalized for this condition or related condition(s)?

Yes
 No

If yes, date of first admission: ___/___/___ (MM/DD/YYYY) Date of first discharge: ___/___/___ (MM/DD/YYYY)

9. On what date did this condition first prevent or restrict the patient from participating? ___/___/___ (MM/DD/YYYY)

10. On what date would the patient not be restricted and medically fit to participate? ___/___/___ (MM/DD/YYYY)

11. Did you advise the insured to cancel their sports registration prior to the season or during the season a result of the sickness or injury? Yes No

If yes, on what date: ___/___/___ (MM/DD/YYYY) If no, on what date was the insured prevented from participating: ___/___/___ (MM/DD/YYYY)

12. If condition was related to pregnancy, date of conception: ___/___/___ (MM/DD/YYYY) Expected Delivery Date: ___/___/___ (MM/DD/YYYY)

13. Was this sickness/injury the sole cause of the patient's medically imposed restrictions? Yes No

If no, please explain:

Additional Physician Comments:

Signature of Physician:	Date Completed: ___/___/___ (MM/DD/YYYY)
Name of Physician:	Telephone Number: <i>(with area code)</i>
Address of Physician:	Taxpayer ID Number: Fax Number: <i>(with area code)</i>

Additional medical information may need to be requested from the treating provider to support your claim.

CLAIM FORM FRAUD STATEMENT FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NEW MEXICO: 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 civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefit.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

AUTHORIZATION

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.

A delay in the processing of this claim may occur if unacceptable proof of loss or an incomplete claim form is submitted. Proof of loss must be submitted within 90 days of the date of loss. IMG or Crum & Forster, United States Fire Insurance Company or its representative reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee. The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees:

1) Any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct.

2) If it is determined by IMG that any information provided by the undersigned in relation to a claim was incorrect, misleading, or fraudulent, IMG reserves the right to recover any payments made as a result of such misinformation. This recovery may include, but is not limited to, reimbursement of claim amounts, associated costs, and legal fees incurred by IMG in investigating and pursuing the recovery.

3) By submitting a claim, the undersigned agrees to cooperate fully with IMG in any investigation related to the claim and to provide any necessary documentation and information requested by IMG to verify the accuracy of the claim. Failure to cooperate or provide the requested documentation may result in the denial of the claim or the initiation of recovery proceedings by IMG.

4) Benefits under the terms and conditions of the insurance contract will be paid only if IMG determines the applicant is entitled to them.

5) By providing an email address and cell phone number on this claim, you agree to electronic communications (including emails and SMS) about any claims that you have submitted.

Insured Signature:

Date: ___/___/___ (MM/DD/YYYY)

Insured Signature:

Date: ___/___/___ (MM/DD/YYYY)

Insured Signature:

Date: ___/___/___ (MM/DD/YYYY)

Insured Signature:

Date: ___/___/___ (MM/DD/YYYY)



Please ensure ALL SECTIONS of this application are filled legibly. Email, mail, or fax, by secure means only.
Address: IMG iTravelInsured® Claims, P.O. Box 3231, Farmington Hills, MI 48333-3231 USA,
Call: 1.866.243.7524 or 1.317.655.9798; **Fax:** +1.317.927.6882; **Email:** itravelclaims@imglobal.com
Web: www.imglobal.com

ACH Transfer Authorization and Agreement Form



For improved user experience, communication, and efficiency, we recommend you submit your claim online via MyIMG. While most IMG products are available for online claims submissions, please continue to use this form for all other products

If using this form, please print legibly and complete ALL SECTIONS of this form. Mail, fax, or submit the completed form online:

Address: IMG iTravelInsured® Claims, P.O. Box 241853, Apple Valley, MN 55124 USA,

Call: 1.866.243.7524 or 1.317.655.9798; **Fax:** +1.317.655.4505

Web: <http://www.imglobal.com/secure-message-center>
www.imglobal.com

INSURED (REQUESTOR) INFORMATION

Name of Insured:		Date of Birth: ___/___/___ (MM/DD/YYYY)	Insured ID Number:
Street Address: (no P.O. Box)			
City:	State/Province:	Postal Code:	Country:
Telephone Number/Email:		Wire sent on behalf of: (if applicable)	

WIRE TRANSFER CURRENCY SELECTIONS

Check destination: <input type="checkbox"/> International (outside U.S.) ¹ <input type="checkbox"/> Domestic (inside U.S.)	For international wires, funds will be sent in the currency of the destination country, where available. If you wish for the funds to be sent in U.S. dollars (funds will be converted by local bank, unless recipient has a U.S. dollar account), please indicate by checking this box: <input type="checkbox"/>
Currency type if international: (name of country and unit)	

BENEFICIARY ("RECIPIENT") INFORMATION

Name:		Telephone Number/Email:	
Address shown on your bank account: (no P.O. Box)			
City:	State/Province:	Postal Code:	Country:
SWIFT Code: (Required for international payments)		International Bank Account Number (IBAN): (Required if sending Euros)	

BENEFICIARY BANK ("RECIPIENT BANK") INFORMATION

Bank Name:			
Branch address linked to your account:			
City:	State/Province:	Postal Code:	Country:
Account Number:		ACH Routing Number:	

INTERMEDIARY BANK INFORMATION (if applicable)

Bank Name:			
Branch address linked to your account:			
City:	State/Province:	Postal Code:	Country:
Account Number:		ACH Routing Number:	

SPECIAL INSTRUCTIONS (e.g., if 100% of the benefits owed should not be transferred to the above beneficiary bank)

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REQUESTOR AUTHORIZATION: By signing below, I request for an accommodation from and for Company to execute the above funds transfer instruction up to the amount of benefits owed in accordance with under the insurance contract for funds transfers set forth in this agreement. I understand and acknowledge recipients may receive less due to fees charged by the recipient's bank and taxes, and any cancellation must occur within 30 minutes of sending the request, unless the funds have already been picked up or deposited.

Authorized Signature and Date: X _____	2 nd Authorized Signature and Date: ___/___/___ (MM/DD/YYYY)
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Message about electronic transmissions: Electronic transmissions via email or fax are not secure and may be intercepted by unauthorized individuals. Please send your claim form by secure means. If you chose to send by insecure means, such as unsecured email, you agree to accept any and all resulting risk.

¹ If sending funds outside of the United States, there may be additional, special fund transfer requirements for international transfers.

Please do not send the Terms & Conditions. Please keep this page for your files. For questions, errors, or issues regarding the transaction, visit www.imglobal.com or call 1.317.655.4500.

Terms and Conditions for Funds Transfers

By requesting a funds transfer order with International Medical Group, Inc., its affiliates, or its subsidiaries (the "Company"), you agree to the following:

Reliance by Company. Company may rely on the information on the form received by it in making your funds transfer. Any errors in the information, including misidentification of Beneficiary(ies), Recipient(s), incorrect or inconsistent account names and numbers, identifying numbers of the intermediary bank or Beneficiary Bank, and misspellings, are your responsibility. If you identify a Beneficiary or other entity by name and account or any other number, payment may be made on the basis of the number and your payment will be final even if the number you provided does not correspond to your Beneficiary or other entity that you have identified.

Bank Fees. Your financial institution may be authorized to debit your account for any fees, costs, or charges related to your funds transfer order. You may have further authorized your financial institution to charge your account a service fee for each funds transfer order you place in accordance with its fee schedule in effect from time to time.

Transfer of Beneficiary Bank. When you place an order with Company for a funds transfer, you must select a financial institution as the Beneficiary Bank for the transfer. For transfers within the United States, the Beneficiary Bank must be a member of the Federal Reserve System or a correspondent bank of such a member, or a Clearing House Interbank Payment System (CHIPS) member. You may request that the funds either be deposited to a particular account at the Beneficiary Bank or that they be held at the Beneficiary Bank for your Beneficiary. The Beneficiary Bank will be responsible for following your instructions and for notifying the Beneficiary that the funds are available. After the funds are transferred to the Beneficiary Bank, they become the property of the Beneficiary Bank. The Beneficiary Bank is responsible to locate, identify, and make payment to your Beneficiary. If your Beneficiary cannot be properly identified, the funds may be returned.

Currency of Transfer. Funds transfers to beneficiaries within the United States are made only in U.S. dollars. For funds transfers to beneficiaries and Beneficiary Banks in other countries, unless you choose to send U.S. dollars, the transfer will be made in the currency of that country. For such funds transfers, the financial institution will convert your U.S. dollar payment to the local currency at that financial institution's exchange rate in effect at that time. The exchange rate usually includes a commission to the financial institution for exchanging the currency. Because of the laws of some countries in which Beneficiary Banks are located, if you request a transfer in U.S. dollars the Company cannot guarantee that your Beneficiary will be able to receive U.S. dollars. If your transfer must be converted to the local currency, the Beneficiary Bank may charge a fee for this exchange. Regardless of the currency transferred, the actual amount that your Beneficiary receives may be reduced by charges imposed by the Beneficiary Bank, including those for exchanging currency.

Means of Transfer. Company uses a variety of banking channels and facilities to make funds transfers, but will ordinarily use electronic means. The Company may choose any conventional means that the Company considers suitable to transfer your funds to your Beneficiary. Because the Company does not maintain banking relations with every bank, the Company sometimes uses one or more intermediary banks to transfer your funds to the Beneficiary Bank. After the Company transmits your order to an intermediary bank, that bank is responsible to complete your order.

Recalls/Amendments. You may recall or amend your funds transfer order only if the Company receives your request prior to our execution of the funds transfer order and at a time that provides Company a reasonable opportunity to act upon that request. If your funds transfer order has been executed by Company, the order can be recalled and amended only if the Beneficiary Bank consents to such a request. Company will not be liable to you for any loss resulting from the failure of the Beneficiary Bank to recall or amend your funds transfer order. If you decide you want to recall your funds transfer order and your order has already been executed by Company, you will first have to check with the Beneficiary Bank to determine whether the Beneficiary Bank can return your funds. If the Beneficiary Bank confirms that the funds are returnable and the funds are returned to Company by the Beneficiary Bank, Company may then send a check for the funds to you. The amount that is returned to you may be less than you originally transferred because of service charges of the Beneficiary Bank or Company. Your check will be in U.S. dollars. If your funds transfer was in a foreign currency, your U.S. dollar check will be at the exchange rate on the date of the check.

Rejection of an Order. The Company reserve the right to reject your funds transfer order. The Company may reject your order if you have insufficient information, the order does not comply with applicable laws, the order is inconsistent with rules and regulations of the financial institutions involved, if your order is incomplete or unclear, or if the Company is unable to fulfill your order for any other reason including but not limited to force majeure events.

Delays, Non-Execution of Funds Transfer Order. While the Company will handle your funds transfer order as expeditiously as possible, you agree that Company will not be responsible for any delay, failure to execute, or misexecution of your order due to circumstances beyond Company's reasonable anticipation or control—including without limitations any inaccuracy, interruption, delay in transmission, or failure in the means of transmission, whether caused by strikes, power failures, equipment malfunctions, or acts or omissions of any intermediary bank or Beneficiary Bank. Company MAKES NO WARRANTIES, EXPRESS OR IMPLIED—INCLUDING THE FAILURE OF ANY INTERMEDIARY BANK OR Beneficiary BANK TO CREDIT YOUR Beneficiary WITH THE AMOUNT OF THE FUNDS TRANSFER AFTER RECEIPT OF SAME WITH RESPECT TO ANY MATTER.

Cut-Off Time For Executing Your Funds Transfer Order. If your funds transfer order is received by Company at or after its established cut-off hour for receipt of funds transfer orders, the earliest your funds transfer order can be executed is the next banking day following receipt of all required information.

Claims. You agree that within one hundred eighty (180) days after you receive notification that your funds transfer order has been executed, you will tell Company of any errors, delays or other problems related to your order. Company will determine whether an error occurred within 90 days after you contact Company and any error will be corrected promptly. Company will tell you the results within 3 business days after completing the investigation. If Company decides there was no error, a written explanation will be sent to you. You may ask to appeal an adverse decision by supplying copies of any documents related to the transaction. If your funds transfer order is delayed or erroneously executed as a result of Company's error, Company's sole obligation to you is to pay via check such amounts as may be required by applicable law. In no event shall Company be responsible for any consequential or incidental damages or expenses in connection with your order. Any claim for interest payable by Company shall not be at any published savings account rate in effect within the state of execution of the funds transfer. In any event, if you fail to notify Company of any claim concerning your funds transfer order within one year from the date that you receive notification that your order has been executed, any claim by you will be barred under applicable law.

Governing Law. The Agreement will be governed by the laws of the state of Indiana which is the location through which you initiated this funds transfer and United States federal law as applicable.

Indemnity. In consideration of the agreement by Company to act upon funds transfer instructions in the manner provided in this Agreement, you agree to indemnify and hold Company harmless from and against any and all claims, suits, judgments, executions, liabilities, losses, damages, costs, and expenses—including reasonable attorney's fees—in connection with or arising out of Company acting upon those funds transfer instructions pursuant to this Agreement. This indemnity will be effective to relieve and indemnify Company against its negligence or misconduct.

² IMG affiliates and subsidiaries currently include the following companies: iTravelInsured, Inc., Akeso Care Management, Inc., International Medical Administrators, Inc., International Medical Group Limited, and IMG Europe AB.

