Student Health Advantage℠ Group Application

(FOR GROUPS OF FIVE OR MORE)

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

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

1	GROUP MEMBER'S NAME		Date of Birth *(month/day/year)*	Government Issued ID Number	Group Member's Requested Effective Date *(month/day/year)*	Group Member's Requested Expiration Date *(month/day/year)*	Group Member's Departure Date If Different Than Group *(month/day/year)*	Monthly Rate*	Daily Rate*	Visa Type
	Country of Citizenship	Residence Country								
1										
2										
3										
4										
5										
(Please attach additional sheets if necessary)							**Subtotal:**	**A**	**B**	

*Use group rate sheet if you have at least five primary insureds; otherwise please use individual rate sheet.

☐ 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 PREMIUM

_____ x _____ = _____
Subtotal **A** *(from Subtotal **A** above)* *# of months* *Total **A***

_____ x _____ = _____
Subtotal **B** *(from Subtotal **B** above)* *# of remainder days beyond whole months* *Total **B***

To pay in monthly installments (please first calculate your total premium in section 4 of the application)

_____ ÷ _____ = _____ x 1.04 = $_____ *(Minimum initial payment required)*
Total Premium Number of months Billing fee Periodic payment

3 SELECT THE COVERAGE PLAN AND PLAN OPTIONS: *(Check one plan and one maximum limit option)*

Select the coverage area and plan option:

○ Coverage excluding U.S.	○ Standard
○ Coverage including U.S.	○ Platinum

Note: If participants within the group would like to designate a beneficiary, please use the Beneficiary Designation form.

4 PLAN PREMIUM

BASE PLAN

(A) Monthly premium total *(From Total A in Section 2)*	_____
(B) Daily premium total *(From Total B in Section 2)*	+_____
A + B =	=_____
(C) Base Premium	=_____

ADDITIONAL COVERAGE OPTIONS

Adventure Sports Rider *(Enter .20 if applicable)*	_____
(D) Total Rider Factor(s)	=_____

TOTAL PREMIUM

Enter the amount from **(C)**	_____
Enter the amount from **(D)** to the right of **1.**	x 1._____ =_____
$20 optional express mail	+_____
TOTAL AMOUNT DUE	=_____

APPLICATION FORM CONTINUED ON BACK

5 GROUP CONTACT AND/OR SPONSORING ORGANIZATION *(if applicable):*

Sponsoring Organization Name (if applicable):			
Mailing Address:	City:	State:	Postal Code:
Responsible Officer Contact Name:	Government Issued ID Number:		
Send confirmation of coverage and communications to the following email:			Phone Number:

☐ **Mail option:** *I do not mind the delays associated with receiving the initial communication via regular mail. I prefer to receive a paper copy of the coverage verification letter and insurance contract.*

If the address provided is in Florida, is the group currently located in Florida? *(Determines applicable surplus lines tax and will not affect coverage)* ◯ Yes ◯ No

Requested Effective Date: ___/___/___ *(MM/DD/YYYY)*	Earliest Date of Departure: ___/___/___ *(MM/DD/YYYY)*
	Requested Expiration Date: ___/___/___ *(MM/DD/YYYY)*
Purpose of Trip & Program:	
Destinations:	

6 PAYMENT METHOD:

◯ Visa ◯ MasterCard ◯ Discover ◯ American Express ◯ JBC ◯ Wire ◯ Check (To IMG) ◯ Money Order (To IMG) ◯ eCheck (ACH) *(available upon request)*

By supplying my account information, I wish 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 he/she has the card or account holder's authorization to use the account and, if not, will take full responsibility for the payment and any charges accruing to it. By submitting the signed application, I agree to pay via my credit card or applicable account the premium amount owed and have read and agree to all terms, conditions, and other statements in this application. I hereby authorize IMG to debit my payment type for the total amount due. In the event that I have chosen to pay premiums semi-annually, quarterly, or monthly, I 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 my credit card periodically as payment installments become due for premiums and renewal premiums. This authorization will remain in effect until revoked by me 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. I understand that I will be given advance notice of the renewal premiums and that they may vary each year. ***This document should only be transmitted to IMG through secure means.***

Card #:	Expiration Date: ___/___ *(MM/YY)*	Cardholder Name:
Signature: *(Required)*	Cardholder Daytime Phone:	Email:
Cardholder Billing Address:		

Payment must be made for the total number of months you want coverage. All payments must be made in U.S. dollars and drawn on U.S. banks.

SUBSCRIPTION. The undersigned on behalf of herself/himself, the Group Contact, Sponsor, Organization, and/or the individual insureds ("applicant(s)") represents and warrants it is signing on his her own behalf or is the authorized agent of the applicant(s) and hereby applies and subscribes to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for the insurance coverage requested above and as underwritten and offered by Sirius Specialty Insurance Corporation (publ) (the Company) on the date of receipt hereof and as administered by the Company's authorized representative and plan administrator, International Medical Group, Inc. (IMG). The applicant(s) understand and agree: (i) the insurance applied for is not an employee welfare benefit plan, accident & health product, health insurance, major medical, nor a health plan subject to or complying with U.S. laws, but is intended for use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) the applicant(s) 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, (iii) 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 (iv) 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 contract and any and all claims and benefits thereunder will be forfeited and waived, (v) by submission of this application and/or any future claim for benefits, the applicant(s) purposefully initiate and take advantage of the privilege of conducting business with the Company in Indiana, through IMG as its managing general underwriter and plan administrator, the contract of insurance represented by the Master Policy and evidenced by the Certificate of insurance will be deemed issued and made in Indianapolis, IN, and sole and exclusive jurisdiction and venue for any legal proceeding relating to the insurance will be in Marion County, Indiana, for which the applicant(s) hereby consent. The applicant(s) consent and agree that Indiana surplus lines law shall govern all rights and claims raised under the insurance contract. **ACKNOWLEDGMENT.** The applicant(s) understand and agree 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) the insurance does not provide benefits for any injury, illness, sickness, disease, or other physical, medical, mental or nervous disorder, condition or ailment that, with reasonable medical certainty, existed at the time of application or at any time during the three (3) years prior to the effective date, whether or not previously manifested, symptomatic or known, diagnosed, treated, or disclosed to the Company prior to the effective date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom (a "pre-existing condition"), and that all charges and/or claims incurred for pre-existing conditions will be excluded from coverage under the insurance, (iii) the subjects of insurance applied for are not intended or considered by the applicant(s), 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. **AUTHORIZATION FOR RELEASE OF INFORMATION.** The applicant(s) 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 them, 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(s) hereby certify, represent and warrant that: (i) they have read the foregoing statements and any marketing materials and sample insurance contract which were made available upon request and prior to the application or that they have been read to them, and the applicant(s) understand them, (ii) they are eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) they are currently in good health and have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing or other medical condition which the applicant(s) foresee may require treatment during the insurance or for which the applicant(s) intend to claim under the insurance, and (iv) each applicant is not hospitalized, disabled, or HIV+. If signed as the legal representative of the applicant, the signer warrants their authority and capacity to so act and to bind each applicant. By acceptance of coverage and/or submission of any claim for benefits, each applicant ratifies the authority of the signer to so act and bind the applicant(s). **THE APPLICANT(S)** represent and warrant that under the insurance offered to the applicant(s), participation in the program is completely voluntary; the sole functions of the Sponsor with respect to the insurance is, without endorsing the program, to permit the insurer to publicize the program to applicant(s), to collect premiums and to remit them to the insurer; and the Sponsor receives no consideration in the form of cash or otherwise in connection with the insurance. The Sponsor acknowledges it must and agrees it will disclose certain material, including reports, statements, notices, and other documents, to applicant(s), beneficiaries and other specified individuals including but not limited to furnishing certain material to all applicant(s) covered under the insurance contract and beneficiaries receiving benefits under the insurance contract at stated times or if certain events occur; furnishing certain material to applicant(s) and beneficiaries upon their request; and making certain material available to applicant(s) and beneficiaries for inspection at reasonable times and places. The Sponsor represents and warrants it will use measures reasonably calculated to ensure actual, prompt receipt of the material by applicant(s), beneficiaries and other specified individuals. **IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA).** The applicant(s) have been informed that they, and any accompanying spouse and dependent(s), also may be subject to the requirements of the Affordable Care Act. The applicant(s) understand and agree that 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 applicant(s') responsibility to determine if the insurance requirements are applicable to them, and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the applicant(s) may incur, for their failure to obtain coverage required by any applicable law including without limitation PPACA. The undersigned hereby arranges for insurance to be offered to the applicant(s). The applicant(s) have voluntarily authorized this action in writing, and the applicant(s) were also given the opportunity to make other arrangements to obtain insurance. These authorizations are kept on file by the undersigned and will be made available to the Company upon request. **E-CONSENT.** The applicant(s) wish to receive information and communicate electronically and prefer to use an e-mail address rather than regular mail. The applicant(s) 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 applicant(s) 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 applicant(s)' wishes. The applicant(s) 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(s) also agree it is their responsibility to provide IMG with true, accurate and complete e-mail address, contact, and other information related to the 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.

Signature of Responsible Officer X_____	Date: ___/___/___ *(MM/DD/YYYY)*

IMG PRODUCER USE ONLY

Producer Number:	Name:		
Email:	Phone Number:		
Address:	City:	State:	Postal Code:

Use group rate sheet if you have at least two primaries and at least five insureds; otherwise please use individual rate sheet.