Cruise Line International SM (CLI)

Application for Group Insurance

Please print legibly and complete ALL sections of this application.

Cruise Line International is a fully insured group benefit plan. The medical portion of the benefit plan is underwritten by Crum & Forster SPC, a member of the Crum & Forster Group of Companies, and is available to members of the Fairmont Specialty Trust, LTD, c/o ITA Global Trust LTD, Camana Bay, Grand Cayman.

1. PROSPECTIVE PARTICIPATING ORGANIZATION ("APPLICANT")

Full Legal Name:		
Address:		
City:	State:	Postal/Zip Code:
At the time of this application, are any applicants currently located in the state of New York? *(If yes, then the purchase of this plan is not available)* ❑ Yes ❑ No		
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 email to:	
MyIMG Group Administrator User ID: *(6 or more characters)*		

❑ 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. WAITING PERIOD FOR FUTURE EMPLOYEES

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

3. EMPLOYER CONTRIBUTION

_____ % of Employee Premium	_____ % of Dependent Premium

4. 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:

5. REQUESTED BENEFITS

Medical Deductible: $	Family Deductible Limit: (2x or 3x)	Period of Coverage Maximum: $
Dental: ❑ Yes ❑ No	Dental Option: ❑ 1 ❑ 2 ❑ 3	
Life & AD&D*: ❑ Yes ❑ No	Life & AD&D Amount: $	

6. OPTIONAL ADD-ONS

❑ Telehealth ❑ Pharmacy Discount Savings (Universal Rx) ❑ Employee Assistance Program Services

* The Life portion of the benefit plan is underwritten by International Medical Insurance Group via Alstead Re, a segregated cell company distributed, managed and administered, as agent for IMIG, by International Medical Group®, Inc. (IMG®).

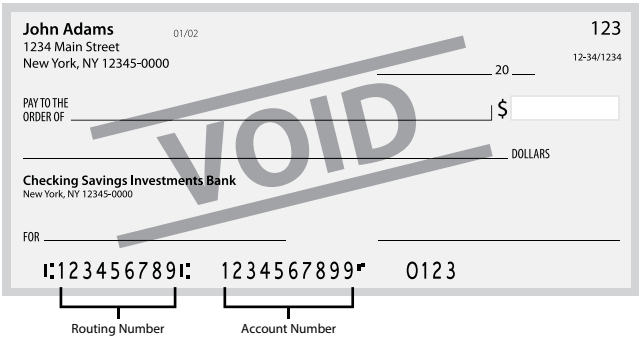
7. MODE AND METHOD OF PAYMENT *Name of participating organization (the employer) applying for group coverage*			
Mode of Payment:	**Select One**	❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual	
Method of Payment:	**Select One**	❑ Visa ❑ MasterCard ❑ Discover ❑ Wire Transfer/ACH ❑ e-Check ❑ American Express	
If Paying by Credit Card:	**Select One**	❑ I want the selected credit card to be debited ONLY for the 1st premium payment, based on the selected mode of payment.	❑ 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.

- 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
Credit card number:
Expiration date:
Name as it appears on card:
Billing address: _____
Phone number:
Email address:
Authorized signature on card:

E-CHECK PAYMENT INFORMATION	
Name of participating organization *(the employer)* applying for group coverage: _____	
Please include the following **e-Check information** on the account:	
Name(s) on account:	
Account number:	
Routing number:	
Select One	❑ Commercial Checking ❑ Consumer Checking ❑ Consumer Savings

All **e-Check** payments must be made in U.S. or Canadian dollars. Please attach VOID check or DEPOSIT SLIP with this form.



attach your void check here

By supplying account information, Applicant wishes 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 Applicant has the card or account holder's authorization to use the account and, if not, will take full responsibility for the payment and any changes accruing to it. By submitting the signed application, the Applicant agrees to pay via credit card or applicable account the premium amount owed and have read and agree to all terms, conditions, and other statements in this application. The Applicant hereby authorizes IMG to debit their payment type for the total amount due. In the event that the Applicant has chosen to pay premiums semi-annually, quarterly, or monthly, they 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 the credit card periodically as payment installments become due for premiums and renewal premiums. The Applicant hereby requests and authorizes IMG to secure premium payments with the selected check information. This authorization will remain in effect until revoked by the Applicant 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. The Applicant understands that they will be given advance notice of the renewal premiums and that they may vary each year.

Printed Name:	Authorized Signature: X _____ *(sign here)*
Title: (if applicable)	
Other Comments:	

NOTE: When sending payment information, health information, and other documents and data regarding your confidential personal information, please send by secure means only.

8. AUTHORIZATION

SUBSCRIPTION
I hereby apply to be a Plan Participant of Fairmont Specialty Trust (the "trust") and to participate in the insurance coverage extended by certain underwriters at HDI Global Specialty ("the insurers") to Plan Participants under the trust (the "coverage").

APPLICATION
The Participating Organization, by its authorized representative, hereby applies for Cruise Line International (CLI) 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.

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 three (3) 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 three (3) 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** _____ *(sign here)*	Date: ___/___/____ *(MM/DD/YYYY)*
Printed Name:	Title/Position:
Producer Signature: **X** _____ *(sign here)*	Date: ___/___/____ *(MM/DD/YYYY)*
Printed Name:	Producer Number:

Send by one of the following secure methods:

Secure Message Center: www.imglobal.com/secure-message-center
Mail: International Medical Group®
2960 North Meridian Street, Ste. 300,
Indianapolis, IN 46208-0509 USA
Fax: +1.317.655.4505

For other inquiries, contact IMG by:

Phone: +1.317.655.4500
Email: insurance@imglobal.com