WORLDWIDE COVERAGE

GLOBAL MEDICAL INSURANCE®

New Business Rates through 12/31/2006

(Includes 2 ½% surplus lines tax where applicable)

INTERNATIONAL MEDICAL GROUP

Global Medical Insurance is a surplus lines product underwritten by Sirius International Insurance Corporation (publ) (the "Company") Distributed, managed and administered, as agent for and on behalf of the Company, by International Medical Group®, Inc. ("IMG®")

ANNUAL PREMIUMS

(more deductible options can be found on the back of this page)

All amounts shown are in U.S. dollars. Please select your deductible carefully, as you will be unable to select a lower deductible when you renew your coverage.

Deductibles	US$250		US$500		US$1,000	
AGE	**MALE**	**FEMALE**	**MALE**	**FEMALE**	**MALE**	**FEMALE**
14 days to 9 years**	First 2 Free* Then 477		First 2 Free* Then 403		First 2 Free* Then 307	
10-18**	519	519	424	424	329	329
*The first two Dependent Children between the ages of 14 days to 9 years are free only when both parents or guardians are insured under the Global Medical Insurance plan. **Dependent child rates are only available when at least one parent or guardian is insured under the Global Medical Insurance plan. Children applying with no parent or guardian insured by Global Medical Insurance must use the Male 19-24 rates.						
19-24	1,115	1,552	960	1,378	747	992
25-29	1,154	1,607	1,008	1,442	781	1,039
30-34	1,275	1,861	1,120	1,696	871	1,258
35-39	1,322	1,903	1,175	1,723	909	1,319
40-44	1,643	2,147	1,452	1,918	1,125	1,488
45-49	1,849	2,233	1,651	2,015	1,280	1,567
50-54	2,247	2,424	2,022	2,205	1,573	1,720
55-59	2,845	2,765	2,608	2,534	2,036	1,979
60-64	3,999	3,770	3,698	3,469	3,096	2,867
65-69	8,258	7,201	7,956	6,900	7,356	6,296
70-74	Please contact IMG or your agent for premium information concerning this age bracket					
Modal Payment Factors* Annual 1.00 Semi Annual .55 Quarterly .28 Monthly .10**						
Optional Maternity Rider $2,500 annual premium						

***For semi-annual, quarterly, and monthly payment modes, IMG will only accept valid Visa, MasterCard, American Express, Discover or JCB credit cards on a pre-authorized basis prior to the expiration date. Your credit card will be debited automatically on the due date(s) of your future premium installment(s).

Note: Choosing the semi-annual payment option (modal payment factor .55) results in total payments of 110% of the annual premium, choosing the quarterly payment option (modal payment factor .28) results in total payments of 112% of the annual premium, and choosing the monthly payment option (modal payment factor .10) results in total payments of 120% of the annual premium.

Rates are valid through 12/31/06

Please see reverse side for the $2,500, $5,000 and $10,000 deductible options

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Deductibles	US$2,500		US$5,000		US$10,000	
AGE	**MALE**	**FEMALE**	**MALE**	**FEMALE**	**MALE**	**FEMALE**
14 days to 9 years**	First 2 Free* Then 276		First 2 Free* Then 248		First 2 Free* Then 224	
10-18**	297	297	267	267	240	240
*The first two Dependent Children between the ages of 14 days to 9 years are free only when both parents or guardians are insured under the Global Medical Insurance plan. **Dependent child rates are only available when at least one parent or guardian is insured under the Global Medical Insurance plan. Children applying with no parent or guardian insured by Global Medical Insurance must use the Male 19-24 rates.						
19-24	658	880	540	722	426	565
25-29	687	920	565	751	442	585
30-34	772	1,114	632	914	498	713
35-39	805	1,166	658	935	517	733
40-44	999	1,322	814	1,050	644	825
45-49	1,135	1,386	927	1,070	730	840
50-54	1,433	1,561	1,174	1,277	921	1,004
55-59	1,795	1,745	1,512	1,469	1,180	1,146
60-64	2,826	2,615	2,345	2,075	1,925	1,714
65-69	5,720	5,168	4,962	4,467	4,089	3,683
70-74	Please contact IMG or your agent for premium information concerning this age bracket					
Modal Payment Factors*	**Annual 1.00**		**Semi Annual .55**		**Quarterly .28**	**Monthly .10**
Optional Maternity Rider $2,500 annual premium						

***For semi-annual, quarterly, and monthly payment modes, IMG will only accept valid Visa, MasterCard, American Express, Discover or JCB credit cards on a pre-authorized basis prior to the expiration date. Your credit card will be debited automatically on the due date(s) of your future premium installment(s).

Note: Choosing the semi-annual payment option (modal payment factor .55) results in total payments of 110% of the annual premium, choosing the quarterly payment option (modal payment factor .28) results in total payments of 112% of the annual premium, and choosing the monthly payment option (modal payment factor .10) results in total payments of 120% of the annual premium.

Rates are valid through 12/31/06

Please see reverse side for the $250, $500 and $1,000 deductible options

WORLDWIDE COVERAGE EXCLUDING U.S./CANADA

GLOBAL MEDICAL INSURANCE®

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ANNUAL PREMIUMS

(more deductible options can be found on the back of this page)

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Deductibles	US$250		US$500		US$1,000	
AGE	**MALE**	**FEMALE**	**MALE**	**FEMALE**	**MALE**	**FEMALE**
14 days to 9 years**	First 2 Free* Then 358		First 2 Free* Then 302		First 2 Free* Then 230	
10-18**	389	389	318	318	247	247
*The first two Dependent Children between the ages of 14 days to 9 years are free only when both parents or guardians are insured under the Global Medical Insurance plan. **Dependent child rates are only available when at least one parent or guardian is insured under the Global Medical Insurance plan. Children applying with no parent or guardian insured by Global Medical Insurance must use the Male 19-24 rates.						
19-24	836	1,164	720	1,034	560	744
25-29	866	1,205	756	1,082	586	779
30-34	956	1,396	840	1,272	653	944
35-39	992	1,427	881	1,292	682	989
40-44	1,232	1,610	1,089	1,439	844	1,116
45-49	1,387	1,675	1,238	1,511	960	1,175
50-54	1,685	1,818	1,517	1,654	1,180	1,290
55-59	2,134	2,074	1,956	1,901	1,527	1,484
60-64	2,999	2,828	2,774	2,602	2,322	2,150
65-69	6,194	5,401	5,967	5,175	5,517	4,722
70-74	Please contact IMG or your agent for premium information concerning this age bracket					
Modal Payment Factors* Annual 1.00 Semi Annual .55 Quarterly .28 Monthly .10**						
Optional Maternity Rider $2,500 annual premium						

***For semi-annual, quarterly, and monthly payment modes, IMG will only accept valid Visa, MasterCard, American Express, Discover or JCB credit cards on a pre-authorized basis prior to the expiration date. Your credit card will be debited automatically on the due date(s) of your future premium installment(s).

Note: Choosing the semi-annual payment option (modal payment factor .55) results in total payments of 110% of the annual premium, choosing the quarterly payment option (modal payment factor .28) results in total payments of 112% of the annual premium, and choosing the monthly payment option (modal payment factor .10) results in total payments of 120% of the annual premium.

Rates are valid through 12/31/06

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ANNUAL PREMIUMS

(more deductible options can be found on the back of this page)

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Deductibles	US$2,500		US$5,000		US$10,000	
AGE	**MALE**	**FEMALE**	**MALE**	**FEMALE**	**MALE**	**FEMALE**
14 days to 9 years**	First 2 Free* Then 207		First 2 Free* Then 186		First 2 Free* Then 168	
10-18**	223	223	200	200	180	180
*The first two Dependent Children between the ages of 14 days to 9 years are free only when both parents or guardians are insured under the Global Medical Insurance plan. **Dependent child rates are only available when at least one parent or guardian is insured under the Global Medical Insurance plan. Children applying with no parent or guardian insured by Global Medical Insurance must use the Male 19-24 rates.						
19-24	494	660	405	542	320	424
25-29	515	690	424	563	332	439
30-34	579	836	474	686	374	535
35-39	604	875	494	701	388	550
40-44	749	992	611	788	483	619
45-49	851	1,040	696	803	548	630
50-54	1,075	1,171	881	958	691	753
55-59	1,346	1,309	1,134	1,102	885	860
60-64	2,120	1,961	1,759	1,556	1,444	1,286
65-69	4,290	3,876	3,722	3,350	3,067	2,762
70-74	Please contact IMG or your agent for premium information concerning this age bracket					
Modal Payment Factors*	**Annual 1.00**		**Semi Annual .55**		**Quarterly .28**	**Monthly .10**
Optional Maternity Rider $2,500 annual premium						

***For semi-annual, quarterly, and monthly payment modes, IMG will only accept valid Visa, MasterCard, American Express, Discover or JCB credit cards on a pre-authorized basis prior to the expiration date. Your credit card will be debited automatically on the due date(s) of your future premium installment(s).

Note: Choosing the semi-annual payment option (modal payment factor .55) results in total payments of 110% of the annual premium, choosing the quarterly payment option (modal payment factor .28) results in total payments of 112% of the annual premium, and choosing the monthly payment option (modal payment factor .10) results in total payments of 120% of the annual premium.

Rates are valid through 12/31/06

Please see reverse side for the $250, $500 and $1,000 deductible options

GLOBAL MEDICAL INSURANCE®

INTERNATIONAL MEDICAL GROUP

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Important Information

Global Medical Insurance offers two options: worldwide coverage or worldwide coverage excluding the U.S. and Canada. Both options provide coverage 24 hours a day, and you have the freedom to choose any doctor or hospital for treatment. Please note the risks and subjects of insurance under this plan are not intended or considered by the Company or IMG to be resident, located, or to be performed in any particular State of the United States, and special eligibility requirements apply. Also, this insurance is not subject to certain portability, access, renewal or other requirements of the Health Insurance Portability and Accountability Act of 1996. Please read and review all of the eligibility requirements, coverage conditions, and pre-existing condition exclusions carefully before purchasing coverage. Marketing brochures and certificate wordings containing complete terms of coverage are available upon request. Please contact IMG or your independent insurance agent/broker for details.

Directions for Completing the Application

[Failure to provide legible and complete information may delay processing of your Application.]

1. In Section 1, print or type your name and the names of all other family members applying for coverage as you want them to appear on your identification card(s). Also, please provide the complete address of your residence outside the U.S., and any mail forwarding address.

2. All Applications must be fully completed, signed and dated to be considered. If any questions are answered "YES" in Section 2, you must identify the family member(s) to whom the "Yes" answer applies, and include the name, address and telephone number of the attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. (Please use the space provided in Section 5, entitled "Medical Information," to provide this information. Please attach additional pages as necessary).

3. ***U.S. Citizens:*** If you or any family member applying for coverage are located in the U.S. on the date of this application, the effective date of this insurance, if issued, will be the later of: a) The effective date requested on the application; or b) The date the insured person departs the U.S.; or c) The date the application is accepted by IMG and a certificate of insurance issued.

   Non-U.S. Citizens: If you or any family member applying for coverage are located in the U.S. on the date of this application and do not plan to depart the U.S., an affidavit of eligibility must be completed. Your insurance agent/broker can assist you in this regard. A new affidavit of eligibility will be required at each renewal.

4. Annual premiums may be paid by check or money order, or by Visa, MasterCard, American Express, Discover or JCB credit cards. IMG will not accept checks or money orders for semi-annual, quarterly, or monthly payment modes. These alternative payment modes are only accepted with pre-authorization to debit your credit card on the due date(s) of your future premium installment(s), and result in total payments of 110%, 112%, and 120%, respectively, of the annual premium. An optional $25 fee may be paid in addition to the premium to have your insurance certificate express mailed to you after approval.

SECTION 1. Please complete for all Family Members applying for coverage

NAME Please print your name below	HEIGHT	WEIGHT	DATE OF BIRTH Mo./day/yr.	COUNTRY OF CITIZENSHIP	PERSONAL IDENTIFICATION NUMBER (PASSPORT, SOCIAL SECURITY, OR DRIVER'S LICENSE)
A. APPLICANT (LAST, FIRST, MIDDLE) ☐MALE ☐FEMALE					
B. SPOUSE (LAST, FIRST, MIDDLE) ☐MALE ☐FEMALE					
C. FIRST CHILD (BELOW AGE 19-LAST, FIRST, MIDDLE) ☐MALE ☐FEMALE					
D. SECOND CHILD (BELOW AGE 19-LAST, FIRST, MIDDLE) ☐MALE ☐FEMALE					
E. THIRD CHILD (BELOW AGE 19-LAST, FIRST, MIDDLE) ☐MALE ☐FEMALE					

ADDRESS OF RESIDENCE OUTSIDE THE U.S.	
STREET ADDRESS	
CITY	STATE, COUNTRY, POSTAL CODE
TELEPHONE	FAX
EMAIL	

U.S. CITIZENS PLEASE COMPLETE THIS AREA	***NON-U.S. CITIZENS PLEASE COMPLETE THIS AREA***
DATE YOU DID (OR WILL) DEPART FROM THE UNITED STATES Mo./day/yr.	**NOTE: IF THE ABOVE ADDRESS IS NOT COMPLETED, AN AFFIDAVIT OF ELIGIBILITY FORM MUST BE COMPLETED.**
IS YOUR EXPECTED LENGTH OF RESIDENCE OUTSIDE THE U.S. AT LEAST 6 OF THE NEXT 12 MONTHS? ☐YES ☐NO	
MAIL FORWARDING ADDRESS IF DIFFERENT FROM ABOVE	**MAIL FORWARDING ADDRESS IF DIFFERENT FROM ABOVE**
STREET ADDRESS	STREET ADDRESS
CITY	CITY
STATE, COUNTRY, POSTAL CODE	STATE, COUNTRY, POSTAL CODE
TELEPHONE	TELEPHONE
FAX	FAX
EMAIL	EMAIL

SECTION 2. Please answer all questions for the Applicant and for each Family Member applying for coverage

	IF THE ANSWER IS YES, PLEASE LIST THE FAMILY MEMBER'S LETTER TO THE RIGHT	FAMILY MEMBER (USE LETTERS FROM SECTION 1)
1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	☐YES ☐NO	
2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?	☐YES ☐NO	
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	☐YES ☐NO	
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	☐YES ☐NO	
5. Do you participate in professional sports?	☐YES ☐NO	
If any individual answered YES to any of the above five questions, he or she does not qualify for this insurance. Thank you for your interest.		
6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please complete Section 5.	☐YES ☐NO	
7. If a non-U.S. citizen, have you or any other applicant resided continuously in the U.S. for the last five (5) years?	☐YES ☐NO	
If any individual answered YES to either of the above two questions, he or she may not qualify for this insurance.		

Questions 8 - 29, below must be answered for the applicant and every family member included on this Application. For any question answered "YES," please identify the family member to whom the answer applies (use the letter that corresponds to the family member from Section 1), and provide complete details of the medical condition at issue in the space provided in Section 5 of this Application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG and the Company reserve the right to request additional medical information.

	IF THE ANSWER IS YES, PLEASE LIST THE FAMILY MEMBER'S LETTER TO THE RIGHT	FAMILY MEMBER (USE LETTERS FROM SECTION 1)
8. During the last twelve (12) months, have you or any family member applying for coverage experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please complete Section 5.	☐YES ☐NO	
9. Have you or any family member applying for coverage ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy? If yes, please explain in Section 5.	☐YES ☐NO	
Have you or any family member applying for coverage ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:		
10. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 5, please complete the following: **a.** Date of most recent blood pressure reading?_____ **b.** Most recent blood pressure reading: _____AS/_____DS **c.** Medications taken (Types and Dosage)_____	☐YES ☐NO	
11. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	☐YES ☐NO	

SECTION 2. (continued)

	IF THE ANSWER IS YES, PLEASE LIST THE FAMILY MEMBER'S LETTER TO THE RIGHT	FAMILY MEMBER (USE LETTERS FROM SECTION 1)
12. Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, in addition to Section 5, please complete the following: **a)** Diabetic Type: I___ or II ___ **b)** Date diagnosed:_____ **c)** Controlled by diet only? Yes__ No__ **d)** Medications (Types and Dosage) _____ **e)** Date of most recent HbA1c Test?_____ **f)** Results of HbA1c Test (1 - 10)_____	☐YES ☐NO	
13. Asthma or allergies? If yes, in addition to Section 5, please specify which one and complete the following: **a)** Date diagnosed:_____ **b)** Has hospitalization or emergency room treatment been required? If yes, describe and list date(s):_____ **c)** Please list known triggers:_____ **d)** Medications (Types and Dosage):_____ **e)** Frequency of attacks:_____	☐YES ☐NO	
14. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind?	☐YES ☐NO	
15. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	☐YES ☐NO	
16. Kidney, urinary tract functions, kidney or bladder stones or infections?	☐YES ☐NO	
17. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	☐YES ☐NO	
18. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?	☐YES ☐NO	
19. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	☐YES ☐NO	
20. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	☐YES ☐NO	
21. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment?	☐YES ☐NO	
22. Congenital, genetic, hereditary or other birth condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	☐YES ☐NO	
23. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	☐YES ☐NO	
24. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus?	☐YES ☐NO	
25. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	☐YES ☐NO	
26. Any other disease, medical problem, illness, injury or condition of any kind not listed?	☐YES ☐NO	
27. Do you or any family member applying for coverage currently use or during the past five years have you used tobacco in any form?	☐YES ☐NO	
28. Have you or any family member applying for coverage ever applied for or purchased insurance through IMG? (If yes, please provide certificate number, if any, and details.)	☐YES ☐NO	
29. During the last twelve (12) months, have you or any family member applying for coverage been covered under any health or medical insurance plan? If yes, please state the name and location of the insurance company, the policy/plan number, and the applicable dates of coverage.	☐YES ☐NO	

SECTION 2. (continued)

SUBSCRIPTION I (we) hereby apply to the Global Medical Services Group Insurance Trust, c/o Community Trust & Investment Co., Noblesville, IN, for Global Medical Insurance® as offered by the Company on the date of its receipt hereof. I (we) understand and agree that: (i) no coverage will be effective until this Application has been duly 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, (iii) IMG and the Company will rely on the accuracy and completeness of the information provided herein, (iv) any misrepresentation or omission contained herein will void the insurance certificate, 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 I (we) purposefully initiate and take advantage of the privilege of conducting business with the Company in Indiana, through IMG as its selected agent and administrator, and invoke the benefits and protections of its laws, and (vi) the contract of insurance represented by the Master Policy and evidenced by the Certificate of insurance shall be deemed issued and made in Indianapolis, IN, and sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Marion County, Indiana, for which applicant(s) hereby consent(s). I (we) agree to use Indiana law for all rights and claims arising under this insurance.

ACKNOWLEDGEMENT I (we) understand and agree that: (i) marketing brochures and certificate wordings are available prior to application upon request, (ii) the insurance agent, broker, website, or other producer, if any, involved with respect to the solicitation of this application is acting solely as my legal agent and representative and is representing my personal interests, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of, the Company or IMG, (iii) any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that, with reasonable medical certainty, existed on or at any time prior to the effective date of coverage, including any subsequent, chronic or recurring complications or consequences related thereto or arising therefrom, whether or not previously manifested or symptomatic, diagnosed or treated prior to the effective date or disclosed herein (a "pre-existing condition"), will be excluded from coverage for two years from the effective date, and thereafter will be limited to $50,000 lifetime per person, with a maximum of $5,000 per person per annual coverage period, (iv) the subjects of insurance applied for are not intended or considered by the applicant(s), the Company or IMG to be resident, located, or to be performed in any particular state of the United States, and (v) the Company, as carrier and underwriter of the plan, is solely liable for the coverages and benefits to be provided thereunder, and IMG acts solely as agent for the Company and has no direct or independent liability under the Master Policy or any Certificate of insurance.

CERTIFICATION I (we) hereby certify, represent and warrant to IMG and the Company that: (i) I (we) have read the questions contained in this Application or they have been read to me (us), and I (we) understand them, (ii) my (our) responses to the questions are true, accurate and complete in all respects as of the date hereof, and that I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto, (iii) I am (we are) currently in good health and, except for the conditions and other information disclosed herein, I (we) 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 condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance, and (iv) if this Application is signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and 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.

MEDICAL RELEASE I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, and/or employment status, to provide such information to IMG and/or the Company.

SATISFACTION GUARANTY/REVIEW PERIOD It is understood I (we) will have 15 days from the effective date to review the insurance Certificate and all benefits, terms, conditions, limitations and exclusions of coverage. If not completely satisfied, I (we) may cancel this insurance by written request retroactive to the effective date and receive a full refund of premium.

Signature of Applicant, Guardian or Proxy **Date (Mo/Day/Yr.)**

Signature of Spouse **Date (Mo/Day/Yr.)**

GLOBAL TERM LIFE INSURANCE℠
GLOBAL DAILY INDEMNITY℠

Underwritten by International Medical Insurance Company℠, Inc. (IMIC℠). Distributed, managed and administered, as agent for IMIC, by International Medical Group®, Inc. ("IMG®"). Global Term Life Insurance and Global Daily Indemnity are only available at the time of application for, and with the purchase of, Global Medical Insurance®.

SECTION 3.

Please indicate the name of each Family Member applying for these optional plans

NAME	BASIC LIFE	SUPPLEMENTAL LIFE	DAILY INDEMNITY
A. APPLICANT	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
B. SPOUSE	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
C. FIRST CHILD	☐YES ☐NO	**NOT AVAILABLE**	☐YES ☐NO
D. SECOND CHILD	☐YES ☐NO		☐YES ☐NO
E. THIRD CHILD	☐YES ☐NO		☐YES ☐NO

FOR EACH INDIVIDUAL APPLYING FOR LIFE INSURANCE, PLEASE INDICATE:		% OF DEATH BENEFIT
APPLICANT A		
PRIMARY BENEFICIARY NAME	RELATIONSHIP	%
CONTINGENT BENEFICIARY NAME	RELATIONSHIP	
APPLICANT B		
PRIMARY BENEFICIARY NAME	RELATIONSHIP	%
CONTINGENT BENEFICIARY NAME	RELATIONSHIP	
APPLICANT C		
PRIMARY BENEFICIARY NAME	RELATIONSHIP	%
CONTINGENT BENEFICIARY NAME	RELATIONSHIP	
APPLICANT D		
PRIMARY BENEFICIARY NAME	RELATIONSHIP	%
CONTINGENT BENEFICIARY NAME	RELATIONSHIP	
APPLICANT E		
PRIMARY BENEFICIARY NAME	RELATIONSHIP	%
CONTINGENT BENEFICIARY NAME	RELATIONSHIP	

If a U.S. citizen, I (we) understand coverage for Global Term Life Insurance will not be effective prior to the date of my (our) departure from the U.S.

x_____ (initial here) Applicant

x_____ (initial here) Spouse

x_____ (initial here) For Covered Children

If accepted for the Global Medical Insurance® plan, I (we) understand that I (we) may qualify for Global Term Life Insurance and/or Global Daily Indemnity underwritten by International Medical Insurance Company. I (we) do hereby apply to the Global Life Insurance Services Group Insurance Trust, Bank of Bermuda, Hamilton, Bermuda, for Global Term Life Insurance and/or Global Daily Indemnity, as indicated above. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorizations, and warranties from the foregoing Application for Global Medical Insurance, and understand and agree that the terms, conditions, restrictions and penalties thereof shall likewise apply hereto. If I (we) have also applied for the optional Global Daily Indemnity plan, I (we) understand that only overnight hospital stays eligible under my (our) Global Medical Insurance plan, excluding pregnancies, are covered. I (we) also understand: (i) there is an additional premium for Global Daily Indemnity, (ii) that in the event IMG does not accept this Application, its sole obligation is to return the premium to me (us), (iii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iv) that the Master Policy for Global Term Life Insurance and Global Daily Indemnity is issued in Bermuda and is governed by its laws.

Signature of Applicant or Guardian	Date (Mo/Day/Yr.)	Signature of Spouse	Date (Mo/Day/Yr.)

SECTION 4.
Deductible Selection and Premium Calculation

INTERNATIONAL MEDICAL GROUP

Note: Deductible Selection, Payment Mode, and Area of Coverage must be the same for all Family Members.

Check one Deductible:	☐ **$250**	☐ **$500**	☐ **$1,000**	☐ **$2,500**	☐ **$5,000**	☐ **$10,000**
Check one Payment Mode:	☐ **Annual = 1.00**	☐ **Semi-annual = 0.55**	☐ **Quarterly = 0.28**	☐ **Monthly = .10**		
Check one Area of Coverage:	☐ **Worldwide**	☐ **Worldwide excluding the U.S. and Canada**				

PREMIUM CALCULATION (Applications without payment of premium will not be approved)
Annual premiums may be paid by check or money order, or by Visa, MasterCard, American Express, Discover or JCB credit cards. IMG will not accept checks or money orders for semi-annual, quarterly, or monthly payment modes. **These alternative payment modes are only accepted with pre-authorization to debit your credit card on the due date(s) of your future premium installment(s) prior to the expiration date.** An optional $25 fee may be paid in addition to the premium to have your insurance certificate express mailed to you after approval.

Enter the ***annual*** Global Medical Insurance premium for each Family Member that corresponds to their age, gender and deductible.

Application cannot be processed unless this section is completed.

Primary Insured $_____
Spouse $_____
1st Child $_____
2nd Child $_____
3rd Child $_____
GMI Subtotal A **$**_____

Optional Benefits

Basic Term Life Premium $240 X_____ = **B** $_____
# of adults applying

Supplemental Term Life $180 X_____ = **C** $_____
# of adults applying

Child Term Life $100 X_____ = **D** $_____
# of children applying

Global Daily Indemnity $100 X_____ = **E** $_____
# of family members applying

Optional Maternity Rider Enter $2,500 here **F** $_____

Subtotal (A+B+C+D+E+F) = G $_____

Total Premium Due

$_____ X _____ + $_____ = **H $**_____
Subtotal G | Modal Factor | Optional Express Mail* | **Premium Amount Due**

Modal Factors: Annual=1.00 Semi-Annual=.55 Quarterly=.28 Monthly=.10

Note: Choosing the semi-annual payment option (modal payment factor .55) results in total payments of 110% of the annual premium, choosing the quarterly payment option (modal payment factor .28) results in total payments of 112% of the annual premium, and choosing the monthly payment option (modal payment factor .10) results in total payments of 120% of the annual premium.

*Optional $25 Express mail - Certificate(s) will be expressed mailed to you after approval

IF YOU CHOOSE EXPRESS MAIL - Please select the address where you would like your Certificate express mailed (as indicated in Section 1)
☐ Residence address ☐ Mail forwarding address
☐ Other (no P.O. boxes please)_____

METHOD OF PAYMENT

☐ Check (annual only) ☐ Money Order (annual only)
☐ MasterCard ☐ Visa ☐ American Express
☐ Discover ☐ JCB
(Authorized signature required for credit card payments)

Checks and money orders should be made payable to International Medical Group, Inc. (IMG). All payments must be made in US dollars and drawn on a US bank at the time application for coverage is made. If paying by credit card, I authorize IMG to debit my Visa/MasterCard/American Express/Discover/JCB credit card account for the total amount due. In the event that I have chosen a semi-annual, quarterly, or monthly modal factor, ***I hereby elect to pre-authorize future credit card payment installments for the balance of the annual period of coverage (12 months from the Effective Date), and hereby request and authorize IMG to charge my credit card periodically as payment installments become due for premiums. This authorization will remain in effect for 12 months, unless earlier revoked by me in writing and IMG actually receives notice of revocation, whereupon continuing coverage may be impacted.*** Coverage purchased by credit card is subject to validation and acceptance by credit card company.

Credit Card #_____

Exp. Date _____
(cannot be earlier than last premium installment due date)

Authorized Signature X_____

Name as it appears on card_____

_____

Daytime Phone# (_____)_____

Billing Address_____

_____

REQUESTED EFFECTIVE DATE:_____
(Must be within 30 days after signature. Coverage will in no event be effective until approved.)

SECTION 5. Medical Information/Prior Insurance

For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. ***Please attach additional pages as necessary.*** IMG and the Company reserve the right to request additional medical information prior to acceptance of Application.

Family Member (use letters from Section 1)	Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone	Date(s) of Treatment

If any family member applying for coverage has ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy (see Section 2, Question 9), please explain below.

Please list the name(s) and address(es) of your family physician(s).

SECTION 6. Renewal Contact Information

Please specify the best way to contact you at renewal:

☐ Mail (please provide address)_____

☐ Fax (please provide fax number)_____

☐ Email (please provide email address)_____

SECTION 7. Insurance Agent/Broker Use Only

IMG Producer/Agent Number # 56508	Agent/Broker Name Carole L. Shaffer
Company Name Carole L. Shaffer	
Address 16768 Whites Store Road - Bldg A	
City, State, Zip Boyds MD 20841-9673	Phone 301.404.1359
Fax 877.587.9133	E-Mail Address clshaffer@shaffergroup.com
Website	
Agent/Broker Signature X	GA #

Please mail or fax this application to:
International Medical Group, Inc.
P.O. Box 88509
Indianapolis, IN 46208-0509 USA

Call direct 317-655-4500 or
toll free (in U.S.) 800-628-4664
Fax 317-655-4505
www.imglobal.com

Address change information or additional contact information should also be directed to IMG.