PATRIOT EXCHANGE PROGRAM℠

MEDICAL INSURANCE FOR INDIVIDUALS AND GROUPS INVOLVED IN EDUCATIONAL OR CULTURAL EXCHANGE

EDUCATIONAL GLOBAL INSURANCE PEP PATRIOT EXCHANGE PROGRAM™

IMG®

Hello. Hola. Hallo. Hej. 您好.

You can greet someone in a foreign country in many ways. When you travel, stay safe and secure by saying hello to Patriot Exchange Program℠, a one-of-a-kind international travel medical insurance plan that brings you Global Peace of Mind® when you're traveling abroad.

GLOBAL *peace of mind*®

Why Consider International Travel Medical Insurance?

Traveling abroad can be an exciting experience, especially when you're involved in an educational or cultural exchange program. But what would happen if you became ill or injured while away from home? Your experience can quickly turn frightening if you're not prepared for a medical emergency.

Whether your trip takes you abroad for a few weeks or an entire year, your cultural exchange experience should be an enjoyable one. You have enough to worry about when you're traveling. Don't let your medical coverage be an uncertainty. International Medical Group® (IMG®) has developed Patriot Exchange Program℠ to provide you, your group, and your dependents traveling with you Coverage Without Boundaries®. The plan offers a complete package of international benefits available 24 hours a day. Simply select the plan option that best fits your needs.

Patriot Exchange Program

The Patriot Exchange Program is designed to meet the U.S. visa insurance requirements for individuals and groups of two or more students studying abroad or participating in a cultural exchange program, including J1 and J2 visa holders. Coverage may be purchased for spouses and unmarried, dependent children traveling with the student/participant. Individuals and groups can select from different plan options—$50,000, $100,000, $250,000, and $500,000 maximum limit per illness/injury. The $50,000 maximum limit per Illness/Injury option does not comply with J1 and J2 visa requirements. This program also offers two different areas of coverage, and an optional add-on rider for high school sports, personal liability, and legal assistance. In addition, groups may purchase annually renewable long term plans that have the flexibility to be tailored to meet specific needs of each program.

How Does the United States Affordable Care Act (ACA) Affect My Coverage?

Non-U.S. Citizens: As non-resident aliens, international students, scholars, and people involved in cultural exchange programs on F, J, M, and Q visas (and certain family members) are not subject to the individual mandate for their first five years in the U.S. All other J categories (teacher, trainee, work and travel, au pair, high school, etc.) are not subject to the individual mandate for two years (out of the past six). Since international students are not subject to the mandate, they are not required to purchase a plan that meets ACA requirements and can purchase the Patriot Exchange Program.

U.S. Citizens: Under the ACA, all U.S. citizens, nationals, and resident aliens are required to purchase minimum essential coverage (ACA-compliant coverage), unless they are exempt. Exempt U.S. citizens include U.S. citizens who reside outside of the U.S. for 330 of any 365-day period, or have a tax home (main place of work or employment, or if you don't have a main place of work or employment, your main residence) in a foreign country, and are a bona fide resident of a foreign country.

Please note that this insurance is not subject to, and does not provide benefits required by, ACA. Since January 1, 2014, ACA requires U.S. citizens, U.S. nationals and resident-aliens to obtain ACA compliant insurance coverage unless they are exempt from ACA (international students on F, J, M and Q visas (and certain family members of students) are not subject to the individual mandate for their first 5 years in the U.S. All other J categories - teacher, trainee, work and travel, au pair, high school, etc. - are not subject to the individual mandate for 2 years out of the past six). Penalties may be imposed on persons who are required to maintain ACA 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 ACA. Please note that it is solely your responsibility to determine if ACA is applicable to you and the Company and IMG shall have no liability whatsoever, including for any penalties that you may incur, for your failure to obtain required ACA compliant coverage. For information on whether ACA applies to you or whether you are eligible to purchase the Patriot Exchange Program, please see IMG's Frequently Asked Questions at imglobal.com/en/client-resources/PPACA-FAQ.aspx. The materials available on this website are for informational purposes only and not for the purpose of providing legal advice. You should contact your attorney to obtain advice with respect to any particular issue or problem. This brochure is intended to convey general information only and not to provide legal advice or opinions.

Global Assistance Services

We know that the reasons for traveling abroad are many and varied—that's why our products are too. Our full-service approach to providing international medical insurance products includes servicing vacationers, those working or living abroad for short or extended periods, people traveling frequently between countries, and those who maintain multiple countries of residence.

But providing insurance coverage is not enough. It's the service and support that matters the most. Since 1990, we've served millions of people around the globe with customer service that's second to none. We provide on-site medical staff who are available 24 hours a day for emergencies, multilingual customer service professionals, and dedicated claims administrators who process tens of thousands of claims each year from all over the world. At IMG, we're with you, providing you Global Peace of Mind®.

PEP Summary of Benefits *(Individual and Group)*

Eligible Medical Expenses are limited to Usual, Reasonable, and Customary Limits per Period of Coverage unless stated as Maximum Limit

Maximum Limit	$5,000,000
Deductible Options	$0, $100, $250, or $500 per illness or injury available
Maximum Limit Per Illness or Injury	Choice of $50,000, $100,000, $250,000, or $500,000
Coinsurance	Company pays 100%
INPATIENT/OUTPATIENT BENEFITS	
Hospital Room and Board	Up to the average semi-private room rate
Intensive Care Unit	Company pays 100% after deductible is met
Physical Therapy	Company pays 100% after deductible is met; one visit per day *(Medical order or treatment plan required)*
Bedside Visit	$1,500 maximum limit. Must be hospitalized in an intensive care unit. Not subject to deductible
Physician Visit	Company pays 100% after deductible is met; one visit per day
Student Health Center	$5 copay per visit. Not subject to deductible
Prescription Drugs	Company pays 100% after deductible is met 90 day dispensing maximum
Urgent Care	$50 copay. Not subject to deductible. Copay is not applicable if you choose a $0 deductible
Walk-in Clinic	$20 copay. Not subject to deductible. Copay is not applicable if you choose a $0 deductible
Eligible Medical Expenses	Company pays 100% after deductible is met
Emergency Room visit with Inpatient Admission	Company pays 100% after deductible is met
Emergency Room visit without Inpatient Admission	Additional $250 deductible
Interfacility Ambulance Transfer *(For services rendered in the U.S.)*	Company pays 100%. Transfer must be a result of an inpatient hospital admission Not subject to deductible
Dental	Non-emergency treatment at a dental provider due to an accident: $500 period of coverage limit per injury; treatment due to unexpected pain to sound, natural teeth: $350 period of coverage limit
Mental or Nervous/Substance Abuse	Not covered if incurred in student health center Inpatient: $10,000 maximum limit Outpatient: $50 maximum limit per day. $500 maximum limit
EVACUATION BENEFITS *(Not subject to deductible)*	
Emergency Medical Evacuation	$50,000 maximum limit
Emergency Reunion	$15,000 maximum limit
Return of Mortal Remains or Cremation/Burial	$25,000 maximum limit for return of mortal remains or $5,000 maximum limit for cremation/burial
Political Evacuation and Repatriation	$10,000 maximum limit
ADDITIONAL BENEFITS	
Accidental Death & Dismemberment	$25,000 principal sum; not subject to deductible
Terrorism	$50,000 maximum limit; not subject to deductible
Sudden & Unexpected Recurrence of a Pre-existing Condition	Eligible medical expenses: $5,000 maximum limit Emergency medical evacuation: $25,000 maximum limit
Pre-existing Conditions	For conditions existing within 36 months before effective date, charges excluded until after 12 months of coverage and then $500 per period of coverage and $1,500 maximum limit
Incidental Trip Coverage *(Available for non-U.S. residents only)*	Up to a cumulative 14 days
OPTIONAL ADD-ON RIDER	
Lost Personal Property	$250 per period of coverage limit
Legal Assistance	$500 per period of coverage limit
Personal Liability - injury to third party Personal Liability - damage to third party's property	$2,000 per period of coverage limit after $100 deductible $500 per period of coverage limit after $100 deductible
Limited High School and College Sports	Company pays 100% after deductible is met

Groups may also purchase a customizable long-term plan. Any coverages, benefits and premium rates offered are in U.S. Dollars.
Benefits are subject to exclusions and limitations. This is only a summary and does not supersede in any way the Certificate of Insurance and governing policy documents (together the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

PEP Services

MyIMG℠

MyIMG is a proprietary online service located at **imglobal.com/member** that allows you to manage your IMG accounts, 24 hours a day, seven days a week, from anywhere in the world. Some features include:

- Submission and management of claims
- Access to Explanation of Benefits (EOBs)
- Initiate precertification
- Access Customer Care via live chat, email, or telephone
- Locate and recommend a provider/facility
- Obtain ID cards and other insurance documents

Extensive Network Access

For students, scholars, and cultural exchange participants when inside the U.S., the UnitedHealthcare Options network is a longstanding reputable tier 1 network that gives you more access to more doctors and services, including:

- Over 895,000 physicians
- 5,600 hospitals in the U.S.
- Retail urgent care facilities
- A streamlined claims process

Students, scholars, and cultural exchange participants when outside the U.S. can also enjoy access to quality healthcare worldwide with our proprietary IPA network that includes:

- Over 18,550 physicians and facilities
- Direct billing arrangements that minimize time and upfront expense

Universal Rx Pharmacy Discount Savings

This discount savings program allows you to purchase prescriptions at one of over 35,000 participating pharmacies in the U.S. and receive the lower of 1) Universal Rx contract price or 2) the pharmacy regular retail price. This program is not insurance coverage; it is purely a discount program.

AkesoCare Management® (AkesoCare℠)

The ability to access quality healthcare is of paramount importance when a medical emergency arises abroad. To coordinate care and provide U.S. and internationally based medical management services, IMG formed AkesoCare, a URAC-accredited, on-site specialized division devoted entirely to medical management. AkesoCare's clinical members are experts at assessing the need for services and ensuring those services are delivered in a timely, cost-effective manner.

urac® ACCREDITED
Health Utilization Management
Expires 05/01/2020

From routine medical care to complex case management, from check-ups to emergency medical evacuations, AkesoCare is there for you. They are committed to patient protection and empowerment, quality operations, and provider compliance. This translates into better care for you—around the world, around the clock.

PEP Optional Riders

Adventure Sports Rider

The Adventure Sports Rider is available on the Patriot Exchange Program for individuals and groups, and their dependents, up to the age of 65. Certain activities designated as adventure sports can be covered up to the maximums listed below. Certain activities are never covered, regardless of whether or not you purchase the Adventure Sports Rider. For a list of all the activities which can be considered to be adventure sports, a sample rider can be provided upon request.

AGE	MAXIMUM LIMIT
Through age 49	$50,000
50 - 59	$30,000
60 - 64	$15,000

Chaperone/Faculty Leader Trip Interruption Rider

Groups may request the Chaperone/Faculty Leader Trip Interruption Rider rider which offers up to $3,000 in benefits. In the event of the original chaperone/leader's hospitalization, a relative's unexpected death, or travel plans must be cancelled as a result of a break-in or destruction due to forces of nature at his/her residence, the subsequent chaperone/faculty leader can be reimbursed for the certain transportation costs to join the group.

**Benefits are subject to exclusions and limitations. This is only a summary and does not supersede in any way the Certificate of Insurance and governing policy documents (together the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.*

PEP RATES

Monthly Rates

COVERAGE EXCLUDING THE U.S.				
Age	$50,000	$100,000	$250,000	$500,000
31 days to 24	$36	$42	$45	$47
25 - 49	$42	$49	$52	$55
50 - 64	$109	$117	$135	$142

Daily Rates

COVERAGE EXCLUDING THE U.S.				
Age	$50,000	$100,000	$250,000	$500,000
31 days to 24	$1.20	$1.40	$1.50	$1.57
25 - 49	$1.40	$1.63	$1.73	$1.83
50 - 64	$3.63	$3.90	$4.50	$4.73

COVERAGE INCLUDING THE U.S.				
Age	$50,000	$100,000	$250,000	$500,000
31 days to 24	$51	$59	$63	$67
25 - 49	$67	$77	$83	$87
50 - 64	$142	$165	$177	$186

COVERAGE INCLUDING THE U.S.				
Age	$50,000	$100,000	$250,000	$500,000
31 days to 24	$1.70	$1.97	$2.10	$2.23
25 - 49	$2.23	$2.57	$2.77	$2.90
50 - 64	$4.73	$5.50	$5.90	$6.20

PEP RATES W/ ADD-ON

Monthly Rates

COVERAGE EXCLUDING THE U.S.				
Age	$50,000	$100,000	$250,000	$500,000
31 days to 24	$38	$44	$47	$49
25 - 49	$44	$51	$55	$58
50 - 64	$114	$123	$142	$149

Daily Rates

COVERAGE EXCLUDING THE U.S.				
Age	$50,000	$100,000	$250,000	$500,000
31 days to 24	$1.27	$1.47	$1.57	$1.63
25 - 49	$1.47	$1.70	$1.83	$1.93
50 - 64	$3.80	$4.10	$4.73	$4.97

COVERAGE INCLUDING THE U.S.				
Age	$50,000	$100,000	$250,000	$500,000
31 days to 24	$54	$62	$66	$70
25 - 49	$70	$81	$87	$91
50 - 64	$149	$173	$186	$195

COVERAGE INCLUDING THE U.S.				
Age	$50,000	$100,000	$250,000	$500,000
31 days to 24	$1.80	$2.07	$2.20	$2.33
25 - 49	$2.33	$2.70	$2.90	$3.03
50 - 64	$4.97	$5.77	$6.20	$6.50

PEP DEDUCTIBLE FACTORS				
Deductible	$0	$100	$250	$500
Factor	1.20	1.00	0.90	0.80

Those interested in purchasing a group plan (e.g. two primaries and at least 5 insureds) are eligible for a 10 percent discount.

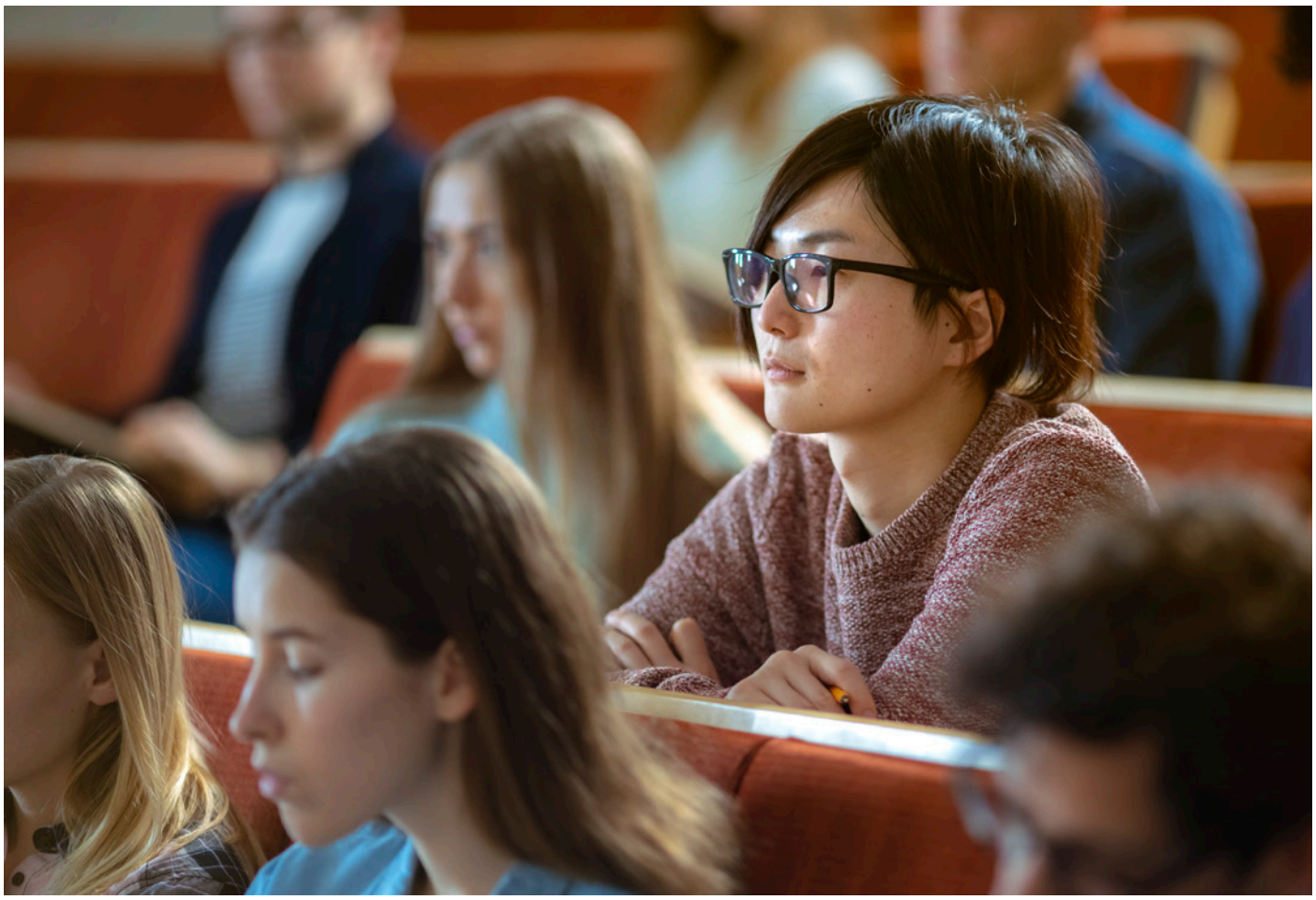
Pricing is based on number of whole months plus remaining days. So July 1 to August 4 = 1 month 3 days.
For your application, you would include one monthly rate and multiply the remaining daily rate times three (days).

Groups may also purchase a customizable long-term plan, for rates please contact your insurance producer or IMG.
U.S. J Visa participants must select $100,000 maximum limit or higher to satisfy the J Visa insurance requirements.

PEP

New premium rates per insured person effective June 5, 2019 for eligible individuals whose applications are approved by IMG. IMG reserve the right to modify or replace these rates at any time.

MEDICAL INSURANCE FOR INDIVIDUALS AND GROUPS INVOLVED IN EDUCATIONAL OR CULTURAL EXCHANGE



GLOBAL peace of mind®

PEP Plan Information

Eligibility

To be eligible to apply to the Patriot Exchange Program plan, you must:

- Be a participant: a student, scholar, intern, teacher, or trainee enrolled in an educational or cultural exchange program for the purposes of teaching, study, research, or receiving on the job training for a temporary period of time
- Be the spouse of a participant or children of a participant and residing outside his/her primary country of residence for a temporary period of time. Primary applicant must hold a J, M, or F visa
- Be at least 31 days old but not yet 65 years old
- Be physically and legally residing in the destination country with the intent to reside there for at least 30 days on the effective date and at renewal
- Not be hospitalized, disabled, pregnant, or HIV+ on the initial effective date

Enrollment Process

Before you begin your travel, simply apply online or fill out the application and calculate the estimated premium for the time period you, your group, and/or your dependents will be traveling. Once you have completed the application, return it to your insurance agent and/or IMG.

Eligible individuals listed on the application and for whom premiums have been paid will be covered from the latest of the following dates:

1. The date IMG approves your completed application and receives the appropriate premium
2. The date you depart from your country of residence
3. The date requested on your application

Fulfillment Kits

IMG processes applications in a quick, timely manner. Once processing is complete, IMG will mail and/or email the fulfillment kit(s) to the address/email listed in the application. The fulfillment kit(s) will include an IMG identification card(s), and the insurance certificate providing a complete description of the rights and benefits under the contract. For your convenience, we will send you this information and may also access it from the IMG website.

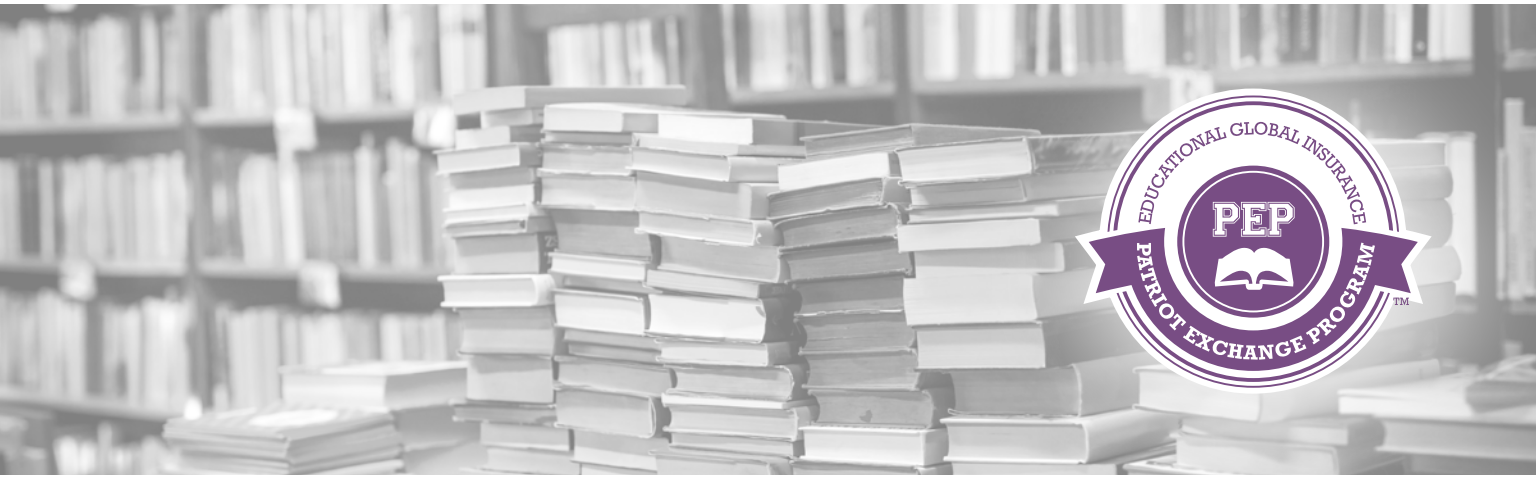
If you do not choose online fulfillment, IMG will mail your fulfillment materials. This may cause delays. We recommend online fulfillment for immediate access to your coverage information.

Conditions of Coverage

1) Coverage and benefits are subject to the deductible, limits, and coinsurance, and all terms of the certificate of insurance and master policy and all governing documents, as summarized in the certificate of insurance. **2)** Coverage under a Patriot Exchange Program plan is secondary to any other coverage. **3)** Coverage and benefits are for eligible medical expenses which are medically necessary and usual, reasonable, and customary. **4)** Charges must be administered or ordered by a licensed physician. **5)** Charges must be incurred during the period of coverage.

Renewal of Coverage

Eligible insureds can request coverage under the plan be renewed a minimum of five (5) days, up to a maximum of 48 continuous months, as long as the premium is paid when due and the insured continues to meet the eligibility requirements of the plan.



PEP Claims Procedure

Precertification:

Certain treatment and supplies including hospital admission, inpatient or outpatient surgery, and other procedures as noted in the certificate wording must be precertified for medical necessity, which means the insured person or their attending physician must communicate with an IMG representative at the number listed on the IMG ID card prior to admission to a hospital before receiving certain treatments and supplies, or performance of a surgery. In case of an emergency admission, the precertification must be made within 48 hours of the admission, or as soon as reasonably possible. If a hospital admission or a surgery is not precertified, eligible claims and expenses will be reduced by 50 percent. It is important to note that precertification is only a determination of medical necessity, not an assurance of coverage, verification of benefits, or a guaranty of payment. All medical expenses eligible for reimbursement must be medically necessary and will be paid or reimbursed at usual, reasonable and customary rates. Please refer to the certificate wording for full details of the precertification requirements.

For precertification and emergency evacuation and repatriation, please call: IMG in the U.S.: 1.800.628.4664 (toll free) or 1.317.655.4500. Call IMG outside the U.S.: 001.317.655.4500 (collect if necessary). This information will also be provided on your ID card.

Note: *You may begin the precertification process through* MyIMG *or the Client Resources section of imglobal.com. Simply look for the precertification option. You will be asked to provide the required information, which can then be submitted electronically. Once we have received all required information and medical records, our utilization management and review team will review the information provided and normally responds to the insured person or the provider within 2 business days. Please note that this online service will only initiate the process for treatment and supplies outlined in the contract, and it should not be used to request precertification for emergency admissions, procedures, or evacuations.*

**Benefits are subject to exclusions and limitations. This is only a summary and does not supersede in any way the Certificate of Insurance and governing policy documents (together the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.*

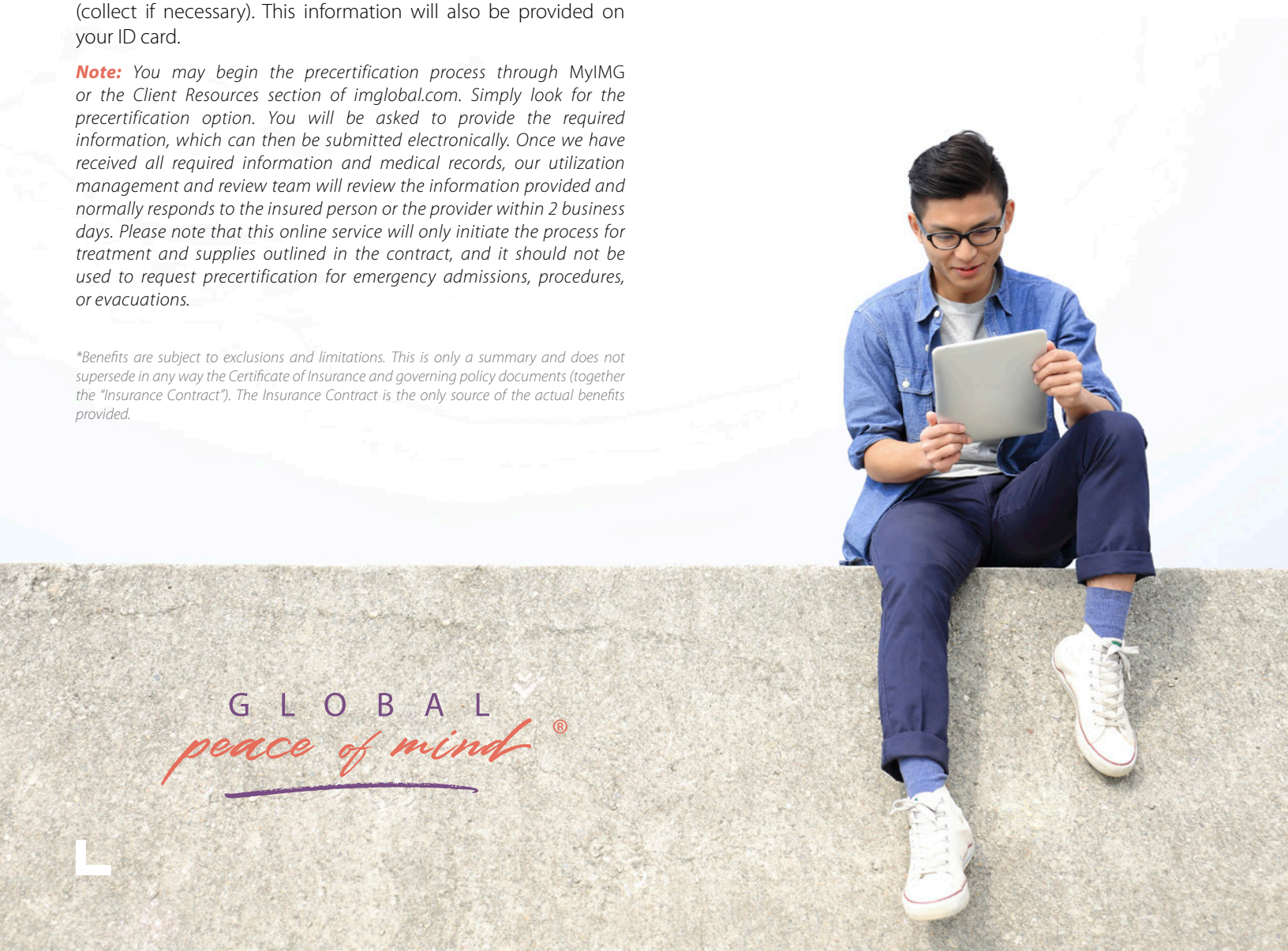
Claims Payment:

All benefits payable under Patriot Exchange Program are subject to the terms and conditions in the certificate of insurance. To make claim processing efficient, claims for eligible medical expenses may be paid in two ways:

1. Eligible expenses that have been paid by or on behalf of the insured person may reimbursed by check directly to the insured person.
2. Eligible expenses that have not yet been paid by the insured person may, at the option of IMG, be paid either to the insured person or directly to the provider.

Claims must be presented to IMG for payment within 180 days from the date the claim was incurred.

Claim form can be submitted online at imglobal.com/member, or emailed to insurance@imglobal.com, or mailed to International Medical Group, P.O. Box 88500, Indianapolis, IN, 46208-0500, USA. All IMG contact numbers, claim forms, and Certificate of Insurance are included in the fulfillment kit. IMG may also be contacted by fax at 1.317.655.4505.



Patriot Exchange Program℠ Individual Application

Please print legibly and complete ALL SECTIONS (front and back) of this application. Mail, fax, or email application to:
International Medical Group, P.O. Box 88509, Indianapolis, IN 46208-0509 USA, Fax +1.317.655.4505, Email: insurance@imglobal.com

1 PRIMARY APPLICANT INFORMATION:

First Name:	Last Name:	Middle:
Government Issued ID Number:	Sex: ☐ Male ☐ Female	
Are you participating in a Work & Travel program? ☐ Yes ☐ No	If yes, Program Name:	

2 FULFILLMENT AND INFORMATION DELIVERY METHOD:

☐ **Communications should be sent via email to:**

Is the applicant a J2 visa holder? ☐ Yes ☐ No (If yes, applicant is only eligible to apply if the J1 visa holder is insured under a plan through his or her education or cultural program). If not, what type of visa does applicant hold? _____

☐ **For mail fulfillment kit purposes ONLY: 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 to the following address:**

Name:		Address:
City:	Postal Code:	Country of Citizenship:
Country of Residence		

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

☐ I AGREE TO THE PROCESSING OF MY PERSONAL INFORMATION TO PROVIDE THE SERVICES I HAVE PURCHASED, INCLUDING TO ADMINISTER CLAIMS, AND TO RECEIVE MEMBER COMMUNICATIONS, IN ACCORDANCE WITH IMG'S PRIVACY POLICY, FOUND AT IMGLOBAL.COM/LEGAL/PRIVACY-POLICY.

☐ I AGREE TO RECEIVE RELEVANT INFORMATION AND OTHER COMMUNICATIONS FROM IMG ABOUT INSURANCE COVERAGES AND SERVICE OPTIONS. I UNDERSTAND THAT I CAN WITHDRAW MY CONSENT AT ANY TIME.

3 PLAN OPTION AND ADDITIONAL COVERAGE OPTIONS:

Select the coverage area and maximum limit per illness/injury. Check one plan and one option:

☐ Coverage includes U.S.	☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $500,000
☐ Coverage excludes the U.S.	☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $500,000
Destination Country(ies):	**Requested Effective Date**: ___/___/___ *(MM/DD/YYYY)*

4 PREMIUM CALCULATION:

Names of Persons to be insured: *Please attach additional sheet for more children*		Date of Birth *(MM/DD/YYYY)*	Monthly Rate	# of Months Travel Coverage	Total	Daily Rate	# of remainder days beyond whole months	Total	Visa Type
Student/ Scholar		___/___/___	_____ x _____ =		_____	_____ x _____ =		_____	
Spouse		___/___/___	_____ x _____ =		_____	_____ x _____ =		_____	
Child 1		___/___/___	_____ x _____ =		_____	_____ x _____ =		_____	
Child 2		___/___/___	_____ x _____ =		_____	_____ x _____ =		_____	
		TOTAL	**(A)**		**(B)**			**(C)**	

5 DEDUCTIBLE OPTION:

SELECT ONE :
Select one deductible by marking it, then enter the applicable rate factor amount in the premium calculation box in Section 5 **(D)**

Deductible	☐ $0	☐ $100	☐ $250	☐ $500
Rate Factor	☐ 1.2	☐ 1.0	☐ .90	☐ .80

Beneficiaries:
If applicants would like to designate a beneficiary, the Beneficiary Designation form can be accessed via imglobal.com/member.

IMG PRODUCER USE ONLY

Producer#: 53811
Name: BETINS
Address: P.O. BOX 1210
City, State, Zip: GRAHAM WA 98338
Phone: 253-238-6374
Email: info@betins.com

APPLICATION FORM CONTINUED ON BACK

Patriot Exchange Program℠ Individual Application

Please print legibly and complete ALL SECTIONS *(front and back)* of this application.

6 PLAN PREMIUM:

BASE PLAN	
(B) Monthly premium total *(from B in Section 4)*	
(C) Daily premium total *(from C in Section 4)*	
B + **C** =	
(D) Deductible rate factor *(see Section 5)*	x
(E) Base Premium	
ADDITIONAL COVERAGE OPTIONS	
(F) Adventure Sports Rider *(Enter .20 if applicable)*	
TOTAL PREMIUM	
Enter the amount from **(E)**	
Enter the amount from **(F)** *to the right of* **1.**	x1. =
Optional express mail $20	+
TOTAL AMOUNT DUE	=

IMG PRODUCER USE ONLY

Producer #: 53811

Name: BETINS

Address: P.O. BOX 1210

City: GRAHAM State: WA Zip: 98338

Phone: 253-238-6374

Email: info@betins.com

7 SUBSCRIPTION:

The undersigned on behalf of the above individuals (applicants) hereby apply and subscribe 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 International 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 applicants 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 applicants 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 applicants 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 applicants hereby consent. The applicants consent and agree that Indiana surplus lines law shall govern all rights and claims raised under the insurance contract. **ACKNOWLEDGEMENT**. The applicants understand and agree that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of applicants 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 anytime during the three (3) years prior to the effective date of this insurance, 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 applicants, 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 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 applicants 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 applicants 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 applicants foresee may require treatment during the insurance or for which the applicants 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 applicants. **IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)**: This insurance is not subject to, and does not provide benefits required by, PPACA. Since January 1, 2014, 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. 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.

Signature of Insured or Proxy *(Required)*	X
Date: ___/___/___ *(MM/DD/YYYY)*	Phone:

8 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.

Card #:	Expiration Date: ___/___ *(MM/YY)*	Cardholder Name:
Authorized 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.

Patriot Exchange Program℠ Group Application

Please print legibly and complete ALL SECTIONS (front and back) of this application. Mail, fax, or email application to:
International Medical Group, P.O. Box 88509, Indianapolis, IN 46208-0509 USA, Fax +1.317.655.4505, Email: insurance@imglobal.com

(Attach additional sheets, if necessary)

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 (#of remainder days beyond whole months)	Visa Type
	Country of Citizenship	Residence Country								
☐ 1										
☐ 2										
☐ 3										
☐ 4										
☐ 5										

Please check the box in front of the applicant's name to identify the Chaperone/Faculty Leader
(if the Chaperone Rider is selected) *(attach additional sheets, if necessary)*
Please note: If the applicant is a J2 visa holder, he/she is only eligible for this plan if the J1 visa holder is insured under a plan through his or her program.

Subtotal: A_____ **B**_____

Will your group have 5 or more insureds? ☐ Yes ☐ No

☐ 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

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

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

3 Select the coverage plan and plan options *(Check one plan and one maximum limit per illness/injury option)*

Select the coverage area and plan option:

☐ Coverage includes U.S.	☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $500,000
☐ Coverage excludes the U.S.	☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $500,000

☐ Check here if you would like the optional Add-On plan.

4 DEDUCTIBLE OPTION:

SELECT ONE :
Select one deductible by marking it, then enter the applicable rate factor amount in the premium calculation box in Section 5.

Deductible	☐ $0	☐ $100	☐ $250	☐ $500
Rate Factor	☐ 1.2	☐ 1.00	☐ .90	☐ .80

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

5 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 =	= _____
Deductible rate factor *(see Section 4)*	x _____
Group discount factor *(Enter .90 if your group consists of at least 5 members)*	x _____
(C) Base Premium	= _____
ADDITIONAL COVERAGE OPTIONS	
Adventure Sports Rider *(enter .20 if applicable)*	_____
Chaperone Rider *(enter .10 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

6 Group Contact and/or Sponsoring Organization (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? ☐ Yes ☐ No
(Determines applicable surplus lines tax and will not affect coverage)

Requested Effective Date: ___/___/___ *(MM/DD/YYYY)*	Earliest Date of Departure: ___/___/___ *(MM/DD/YYYY)*
	Requested Expiration Date: ___/___/___ *(MM/DD/YYYY)*

Purpose of Trip & Program:

Destinations:

7 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, Sponsor 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, Sponsor represents and warrants that it 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, Sponsor agrees 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.

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 the Sponsor or Organization and the above individuals (collectively "applicants") represents and warrants it is the authorized agent of the applicants and hereby applies and subscribes, for and on behalf of each individual listed on the application form, 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 International Insurance Corporation (publ) (the Company) on the date of its receipt hereof, and as administered by the Company's authorized representative and plan administrator, International Medical Group, Inc. (IMG). The applicants, 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 applicants 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 applicants 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(s) 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 applicants consent. The applicants consent and agree that Indiana surplus lines law shall govern all rights and claims raised under the insurance contract. **Acknowledgment.** The applicants 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 applicants 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 of this insurance, 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 applicants, 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 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 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 applicants 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 applicants 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 the applicants foresee may require treatment during the insurance or for which the applicants 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 his/her authority and capacity to so act and to bind the applicants. 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 that applicant. **The applicants** represent and warrant that under the insurance offered to the applicants, 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 applicants, 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 applicants, beneficiaries and other specified individuals including but not limited to furnishing certain material to all applicants 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 applicants and beneficiaries upon their request; and making certain material available to applicants 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 applicants, beneficiaries and other specified individuals. **Patient Protection and Affordable Care Act (PPACA).** Sponsor has informed all participants that they, and any accompanying spouse and dependent(s), also may be subject to the requirements of the Affordable Care Act. The applicants understand and agree that: (i) this insurance is not subject to, and does not provide benefits required by, PPACA, (ii) Since January 1, 2014, PPACA requires U.S. citizens, U.S. nationals, and resident aliens to obtain PPACA compliant insurance coverage unless they are exempt from PPACA, and penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so, (iii) eligibility to purchase, extend or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA, and (iv) the applicants understand that it is solely their responsibility to determine if PPACA is 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. The Sponsor hereby arranges for insurance to be offered to the applicants, the applicants have voluntarily authorized this action in writing, and the applicants were also given the opportunity to make other arrangements to obtain insurance. These authorizations are kept on file by the Sponsor and will be made available to the Company upon request. **E-Consent.** The applicants wish to receive information and communicate electronically, and prefer to use email rather than regular mail. The applicants agree IMG, its affiliates, and subsidiaries may provide the recipient 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. 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 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: 53811	Name: BETINS		
Email: info@betins.com	Phone Number: 253-238-6374		
Address: P.O. BOX 1210	City: GRAHAM	State: WA	Postal Code: 98338

P.O. Box 88509
2960 North Meridian Street, Indianapolis, IN, 46208-0509, USA

For sales questions, please call: +1.866.368.3724 or 1.317.655.9799
For all other inquiries, please call: +1.800.628.4664 or 1.317.655.4500
Fax: +1.317.655.4505

Email: insurance@imglobal.com

IMG acts as the authorized representative and plan administrator for and on behalf of Sirius International.

Coverage is underwritten and issued by Sirius International Insurance Corporation, rated A (excellent) by A.M. Best and A- by Standard & Poor's (at the time of printing).

This invitation to inquire allows eligible applicants an opportunity to seek information about the insurance offered and is limited to a brief description of any loss for which benefits may be payable. Benefits are offered as described in the insurance contract. Benefits are subject to all deductibles, coinsurance, provisions, terms, conditions, limitations, and exclusions in the insurance contract. The contract does contain a pre-existing condition exclusion and does not cover losses or expenses related to a pre-existing condition.

PATRIOT
EXCHANGE
PROGRAM℠

IMG PRODUCER USE ONLY

BETINS
P.O. BOX 1210
GRAHAM, WA 98338
Phone: 253-238-6374
Fax: 253-238-6382
info@betins.com
http://www.betins.com

This invitation to inquire allows eligible applicants an opportunity to seek information about the insurance offered and is limited to a brief description of any loss for which benefits may be payable. Benefits are offered as described in the insurance contract. Benefits are subject to all deductibles, coinsurance, provisions, terms, conditions, limitations and exclusions in the insurance contract.

Certain contracts do contain a pre-existing condition exclusion and do not cover losses or expenses related to a pre-existing condition.