STUDENT HEALTH ADVANTAGE℠

WORLDWIDE MEDICAL INSURANCE FOR INTERNATIONAL STUDENTS AND SCHOLARS

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 Student Health Advantage℠, a one-of-a-kind international medical insurance plan that brings you Global Peace of Mind® when you're traveling abroad.
GLOBAL peace of mind®

Secure, Reliable Medical Insurance

As an international student or scholar, the thrill of studying abroad is extraordinary. Your new surroundings are amazing and you're involved in new and exciting experiences. You're seeing and visiting places for the first time, while receiving the benefits of a long-term education.

Caught up in all of the excitement, you may not think about falling ill or becoming injured during your studies. Without warning, your experience abroad can quickly become frightening and risky if you're not prepared for a medical emergency. As an international student, peace of mind is a priority when you study abroad.

Your educational adventure or cultural exchange program should be enjoyable and gratifying. Maintaining the ability to be flexible and responsive, International Medical Group® (IMG®) has developed Student Health Advantage℠, an international medical plan designed to specifically meet the needs of international students, scholars, and people involved in long-term educational and cultural exchange programs. The plan offers a complete package of benefits while outside your home country available 24 hours a day, providing you with Global Peace of Mind®. After all, you are global. Your medical insurance should be too.

Student Health Advantage℠

- Meets U.S. student, scholar, and cultural exchange program visa requirements
- Coverage for individuals or groups of two or more primaries and their dependents
- Mental & nervous disorders and substance abuse coverage
- Intercollegiate/interscholastic/intramural or club sports coverage
- Maternity coverage (Platinum only)
- International emergency care

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 eligible to purchase Student Health Advantage.

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 Student Health Advantage, 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.

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®.

SHA Summary of Benefits **Standard Plan**

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

Maximum Limit	Student: $500,000; Dependent: $100,000
Maximum Limit per Illness or Injury	Student: $300,000; Dependent: $100,000
Deductible	$100 per illness or injury Student health center: $5 copay per visit
Coinsurance	Outside of the U.S.: Company pays 100% In PPO network or student health center within the U.S.: Company pays 100% Out of PPO network if within the U.S.: Company pays 80% of eligible expenses up to $5,000; then 100% thereafter
Hospital Room and Board	Average semi-private room rate, including nursing service
Intensive Care	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally
Emergency Room Injury	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally
Emergency Room Illness resulting in Hospitalization	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally
Emergency Room Illness Without Inpatient Admission	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally; Subject to additional $250 deductible
Mental or Nervous/Substance Abuse	Outpatient: $50 per day; $500 maximum limit; Inpatient: After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally up to $10,000 maximum limit; Student health center treatment: $0
Prescription Drugs	Inpatient: After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally Outpatient: 50% of actual charges 90 day dispensing maximum
Physical Therapy *(Medical order or treatment plan required)*	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally; limit one visit per day
Local Ambulance	$350 per illness resulting in an inpatient hospitalization or injury
Dental	Non-emergency treatment at a dental provider due to an accident - $500 period of coverage limit per injury; unexpected pain to sound, natural teeth - $350 period of coverage limit
Eligible Medical Expenses	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally
Interfacility Ambulance Transfer *(For services rendered in the U.S.)*	Company pays 100%. Transfer must be a result of an inpatient hospital admission
Emergency Medical Evacuation	$500,000 maximum limit
Emergency Reunion	$50,000 maximum limit
Return of Mortal Remains	$50,000 maximum limit
Political Evacuation and Repatriation	$10,000 maximum limit
Intercollegiate/Interscholastic/Intramural or Club Sports	$5,000 period of coverage limit per illness or injury
Incidental Trip Coverage	Up to a cumulative 14 days (available for non-U.S. residents only)
Pre-existing Conditions	Charges excluded until after 12 months of continuous coverage
Terrorism	$50,000 maximum limit
AD&D	Student: $25,000 principal sum; Spouse: $10,000 principal sum; Dependent child: $5,000 principal sum Accidental dismemberment percentage of principal sum
Personal Liability *(Secondary to any other insurance)*	$10,000 combined maximum limit Injury to third person: subject to a $100 per injury deductible Damage to third person's property: subject to a $100 per damage deductible

All coverage and benefits in this Policy are in United States (U.S.) dollars. Benefits are subject to the exclusions and limitations and are payable only at Usual, Reasonable and Customary charges. This is a summary and does not supersede in anyway the Certificate of Insurance and governing policy documents (together the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided. Eligible medical expenses are limited to usual, reasonable and customary.

SHA Summary of Benefits **Platinum Plan**

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

Benefit	Coverage
Maximum Limit	Student: $1,000,000; Dependent: $100,000
Maximum Limit per Illness or Injury	Student: $500,000; Dependent: $100,000
Deductible	For treatment received outside of the U.S.: $25 per illness or injury For treatment received within the U.S.: PPO provider: $25 per illness or injury; non-PPO provider: $50 per illness or injury; student health center: $5 copay per visit
Coinsurance	Outside of the U.S.: Company pays 100% In PPO network or student health center within the U.S.: Company pays 100% Out of PPO network if within the U.S.: Company pays 80% of eligible expenses up to $5,000; then 100% thereafter
Hospital Room and Board	Average semi-private room rate, including nursing service
Intensive Care	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally
Maternity and Newborn Care	$5,000 maximum limit. Benefit includes newborn routine care during the first 31 days of life After deductible is met, company pays 60% of eligible expenses out-of-network (U.S.), 80% in-network (U.S.) and 100% internationally
Emergency Room Injury	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally
Emergency Room Illness Resulting in Hospitalization	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally
Emergency Room Illness Without Inpatient Admission	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally; subject to additional $250 deductible
Mental or Nervous/Substance Abuse	Outpatient: $50 per day; $500 maximum limit; inpatient: After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally up to $10,000 maximum limit; student health center treatment: $0
Prescription Drugs	Inpatient: After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally Outpatient: 50% of actual charges 90 day dispensing maximum
Physical Therapy *(Medical order or treatment plan required)*	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally; limit one visit per day
Local Ambulance	$750 per illness resulting in an inpatient hospitalization or injury
Dental	Non-emergency treatment at a dental provider due to an accident - $500 period of coverage limit per injury; unexpected pain to sound, natural teeth - $350 period of coverage limit
Eligible Medical Expenses	After deductible is met, company pays 80% of expenses out-of-network (U.S.) or 100% in-network (U.S.) and internationally
Interfacility Ambulance Transfer *(For services rendered in the U.S.)*	Company pays 100%. Transfer must be a result of an inpatient hospital admission
Emergency Medical Evacuation	$500,000 maximum limit
Emergency Reunion	$50,000 maximum limit
Return of Mortal Remains	$50,000 maximum limit
Political Evacuation and Repatriation	$10,000 maximum limit
Intercollegiate/Interscholastic/Intramural or Club Sports	$5,000 period of coverage limit per illness or injury
Incidental Trip Coverage	Up to a cumulative 14 days (available for non-U.S. residents only)
Pre-existing Conditions	Charges excluded until after six months of continuous coverage
Terrorism	$50,000 maximum limit
AD&D	Student: $25,000 principal sum; spouse: $10,000 principal sum; dependent child: $5,000 principal sum; accidental dismemberment percentage of principal sum
Personal Liability *(Secondary to any other insurance)*	$10,000 combined maximum limit Injury to third person: Subject to a $100 per injury deductible Damage to third person's property: Subject to a $100 per damage deductible

All coverage and benefits in this Policy are in United States (U.S.) dollars. Benefits are subject to the exclusions and limitations and are payable only at Usual, Reasonable and Customary charges . This is a summary and does not supersede in anyway the Certificate of Insurance and governing policy documents (together the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided. Eligible medical expenses are limited to usual, reasonable and customary.

SHA STANDARD

Monthly Rates

COVERAGE EXCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$50	$292	$60
19 - 23	$56	$292	$60
24 - 30	$74	$320	$60
31 - 40	$112	$426	$60
41 - 50	$181	$437	$60
51 - 64	$242	$426	$60

COVERAGE INCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$64	$336	$80
19 - 23	$84	$336	$80
24 - 30	$98	$372	$80
31 - 40	$176	$495	$80
41 - 50	$286	$511	$80
51 - 64	$382	$495	$80

Daily Rates

COVERAGE EXCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$1.67	$9.73	$2.00
19 - 23	$1.87	$9.73	$2.00
24 - 30	$2.47	$10.67	$2.00
31 - 40	$3.73	$14.20	$2.00
41 - 50	$6.03	$14.57	$2.00
51 - 64	$8.07	$14.20	$2.00

COVERAGE INCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$2.13	$11.20	$2.67
19 - 23	$2.80	$11.20	$2.67
24 - 30	$3.27	$12.40	$2.67
31 - 40	$5.87	$16.50	$2.67
41 - 50	$9.53	$17.03	$2.67
51 - 64	$12.73	$16.50	$2.67

SHA PLATINUM

Monthly Rates

COVERAGE EXCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$85	$501	$92
19 - 23	$94	$501	$92
24 - 30	$124	$548	$92
31 - 40	$135	$730	$92
41 - 50	$305	$750	$92
51 - 64	$404	$730	$92

COVERAGE INCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$108	$576	$122
19 - 23	$142	$576	$122
24 - 30	$164	$636	$122
31 - 40	$294	$847	$122
41 - 50	$481	$875	$122
51 - 64	$642	$847	$122

Daily Rates

COVERAGE EXCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$2.83	$16.70	$3.07
19 - 23	$3.13	$16.70	$3.07
24 - 30	$4.13	$18.27	$3.07
31 - 40	$4.50	$24.33	$3.07
41 - 50	$10.17	$25.00	$3.07
51 - 64	$13.47	$24.33	$3.07

COVERAGE INCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$3.60	$19.20	$4.07
19 - 23	$4.73	$19.20	$4.07
24 - 30	$5.47	$21.20	$4.07
31 - 40	$9.80	$28.23	$4.07
41 - 50	$16.03	$29.17	$4.07
51 - 64	$21.40	$28.23	$4.07

SHA

New premium rates per insured person effective June 13, 2018 for eligible individuals whose applications are approved by IMG. IMG reserve the right to modify or replace these rates at any time.

Use this sheet for groups with at least five primaries.

SHA GROUP RATES

SHA STANDARD

Group Monthly Rates

COVERAGE EXCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$44	$249	$52
19 - 23	$48	$249	$52
24 - 30	$63	$272	$52
31 - 40	$95	$363	$52
41 - 50	$154	$373	$52
51 - 64	$206	$363	$52

COVERAGE INCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$54	$287	$67
19 - 23	$72	$287	$67
24 - 30	$83	$317	$67
31 - 40	$149	$421	$67
41 - 50	$244	$435	$67
51 - 64	$325	$421	$67

Group Daily Rates

COVERAGE EXCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$1.47	$8.30	$1.73
19 - 23	$1.60	$8.30	$1.73
24 - 30	$2.10	$9.07	$1.73
31 - 40	$3.17	$12.10	$1.73
41 - 50	$5.13	$12.43	$1.73
51 - 64	$6.87	$12.10	$1.73

COVERAGE INCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$1.80	$9.57	$2.23
19 - 23	$2.40	$9.57	$2.23
24 - 30	$2.77	$10.57	$2.23
31 - 40	$4.97	$14.03	$2.23
41 - 50	$8.13	$14.50	$2.23
51 - 64	$10.83	$14.03	$2.23

SHA PLATINUM

Group Rates - Monthly

COVERAGE EXCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$70	$410	$76
19 - 23	$78	$410	$76
24 - 30	$102	$449	$76
31 - 40	$153	$599	$76
41 - 50	$250	$615	$76
51 - 64	$332	$599	$76

COVERAGE INCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$88	$472	$101
19 - 23	$116	$472	$101
24 - 30	$135	$522	$101
31 - 40	$242	$695	$101
41 - 50	$395	$718	$101
51 - 64	$527	$695	$101

Group Rates - Daily

COVERAGE EXCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$2.33	$13.67	$2.53
19 - 23	$2.60	$13.67	$2.53
24 - 30	$3.40	$14.97	$2.53
31 - 40	$5.10	$19.97	$2.53
41 - 50	$8.33	$20.50	$2.53
51 - 64	$11.07	$19.97	$2.53

COVERAGE INCLUDING THE U.S.			
Age	Student	Spouse	Dep Child
31 days to 18	$2.93	$15.73	$3.37
19 - 23	$3.87	$15.73	$3.37
24 - 30	$4.50	$17.40	$3.37
31 - 40	$8.07	$23.17	$3.37
41 - 50	$13.17	$23.93	$3.37
51 - 64	$17.57	$23.17	$3.37

New premium rates per insured person effective June 13, 2018 for eligible individuals whose applications are approved by IMG. IMG reserve the right to modify or replace these rates at any time.

SHA Plan Information

Eligibility

To be eligible to apply to the Student Health Advantage 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 J1, M1 or F1 visa, and spouse must apply with primary applicant—they cannot apply alone
- 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 primary country of residence
3. The date requested on your application

Eligible individuals may pay their rates on a monthly basis, but will incur a 4 percent admin fee.

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 insurance contract, which includes the master policy and all governing documents as summarized in the certificate of insurance. **2)** Coverage under a Student Health Advantage 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 whose initial coverage is at least three months can request coverage under the plan be renewed monthly for up to 12 month periods, for a maximum of 60 continuous months, as long as the premium is paid when due and the insured continues to meet the eligibility requirements of the plan.

SHA OPTIONAL RIDERS

ADVENTURE SPORTS RIDER: The Adventure Sports Rider is available for eligible participants. 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 the Adventure Sports Rider is issued. For a list of activities which can be considered to be adventure sports, a sample rider can be provided upon request. *(Available to insureds through age 64)*

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

**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.*

SHA 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 guarantee 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, 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 two 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.*

Claims Payment:
All benefits payable under Student Health Advantage 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 be reimbursed by check directly to the insured person
1. 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. IMG may also be contacted by fax at 1.317.655.4505.

SHA 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 and scholars when in 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 and scholars 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.

Akeso Care 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, an on-site specialized division devoted entirely to medical management.

Health Utilization Management Expires 05/01/2020

The clinical staff consists of qualified physicians and registered nurses are experts at assessing the need for medical services and ensuring those services are delivered in a timely, cost-effective manner. AkesoCare has international medical experience, providing services in more than 170 countries worldwide.

AkesoCare is accredited by URAC, an independent, nonprofit organization that is internationally recognized for promoting continuous improvement in the quality and efficiency of healthcare management. Through a rigorous and comprehensive review that ensures ongoing compliance, AkesoCare earned its URAC accreditation in Health Utilization Management.

From routine medical care to complex case management and 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.

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Student Health Advantage℠ 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	

2 FULFILLMENT AND INFORMATION DELIVERY METHOD:

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

☐ **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:

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 plan option:

☐ Coverage excluding U.S. ☐ Coverage including U.S.	☐ Standard ☐ Platinum
Country of Citizenship:	Country of Residence:
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)	

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

APPLICATION FORM CONTINUED ON BACK

5 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) Base premium	________
ADDITIONAL COVERAGE OPTIONS	
(E) Adventure Sports Rider *(Enter .20 if applicable)*	x________
TOTAL PREMIUM	
Enter the amount from **(D)**	________
Enter the amount from **(E)** *to the right of the* **1.**	x **1.** ________ =________
Optional express mail $20	+________
TOTAL PREMIUM AMOUNT DUE	=________
To pay in monthly installments, divide your total by the number of months and multiply by 1.04 *(Minimum initial payment required)*	÷________ # of months x 1.04 = ________ Periodic Payment

IMG PRODUCER USE ONLY		
Producer #:		
Name:		
Address:		
City:	State:	Zip:
Phone:		
Email:		

6 APPLICATION TERMS:

SUBSCRIPTION. The undersigned on their own behalf or as an authorized representative 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. **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 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 time frame outlined in the contract prior to the effective date, whether or not previously manifested, symptomatic or known, diagnosed, treated, or disclosed to the Company prior to the effective date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom (a "pre-existing condition"), and that all charges and/or claims incurred for pre-existing conditions will be excluded from coverage as described in the Certificate of Insurance, which is incorporated by reference here and can be accessed at imglobal.com/sample-contracts, (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. 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:

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, 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.

Student Health Advantage℠ Group Application

(FOR GROUPS OF FIVE OR MORE)

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

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

☐ I AM AN AUTHORIZED REPRESENTATIVE OF THE GROUP MEMBERS AND THE GROUP MEMBERS AGREE TO THE PROCESSING OF THEIR PERSONAL INFORMATION TO PROVIDE THE SERVICES THEY HAVE PURCHASED, INCLUDING TO ADMINISTER CLAIMS, AND TO RECEIVE MEMBER COMMUNICATIONS, IN ACCORDANCE WITH IMG'S PRIVACY POLICY.

☐ I AM AN AUTHORIZED REPRESENTATIVE OF THE GROUP MEMBERS AND THE GROUP MEMBERS AGREE TO RECEIVE RELEVANT INFORMATION AND OTHER COMMUNICATIONS FROM IMG ABOUT INSURANCE COVERAGES AND SERVICE OPTIONS. THE GROUP MEMBERS UNDERSTAND THAT THEY CAN WITHDRAW CONSENT AT ANY TIME.

2 Premium

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

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

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

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

3 Select the coverage plan and plan options: *(Check one plan and one maximum limit option)*

Select the coverage area and plan option:

☐ Coverage excluding U.S.
☐ Coverage including U.S.

☐ Standard
☐ Platinum

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

4 Plan Premium

BASE PLAN

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

ADDITIONAL COVERAGE OPTIONS

Adventure Sports Rider *(Enter .20 if applicable)* ______

(D) Total Rider Factor(s) = ______

TOTAL PREMIUM

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

TOTAL AMOUNT DUE = ______

5 Group Contact and/or Sponsoring Organization (if applicable):

Sponsoring Organization Name (if applicable):

Mailing Address:	City:	State:	Postal Code:

Responsible Officer Contact Name:	Government Issued ID Number:

Send confirmation of coverage and communications to the following email:	Phone Number:

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

If the address provided is in Florida, is the group currently located in Florida? ☐ 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:

6 Payment Method:

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

By supplying my account information, 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 herself/himself, the Group Contact, Sponsor, Organization, and/or the individual insureds ("applicant(s)") represents and warrants it is signing on his her own behalf or is the authorized agent of the applicant(s) and hereby applies and subscribes to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for the insurance coverage requested above and as underwritten and offered by Sirius 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 applicant(s) understand and agree: (i) the insurance applied for is not an employee welfare benefit plan, accident & health product, health insurance, major medical, nor a health plan subject to or complying with U.S. laws, but is intended for use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) the applicant(s) must pay premiums for the entire period of coverage in advance, and no coverage will be effective until the required premium has been paid and this application has been accepted in writing by the Company, (iii) no modification or waiver relating to this application or the coverage applied for will be binding upon the Company or IMG unless approved in writing by an officer of the Company or IMG, and (iv) the Company relies on the accuracy, truthfulness, and completeness of the information provided herein and any misrepresentation or omission contained herein will void the insurance contract and any and all claims and benefits thereunder will be forfeited and waived, (v) by submission of this application and/or any future claim for benefits, the applicant(s) purposefully initiate and take advantage of the privilege of conducting business with the Company in Indiana, through IMG as its managing general underwriter and plan administrator, the contract of insurance represented by the Master Policy and evidenced by the Certificate of insurance will be deemed issued and made in Indianapolis, IN, and sole and exclusive jurisdiction and venue for any legal proceeding relating to the insurance will be in Marion County, Indiana, for which the applicant(s) hereby consent. The applicant(s) consent and agree that Indiana surplus lines law shall govern all rights and claims raised under the insurance contract. **ACKNOWLEDGMENT.** The applicant(s) understand and agree that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of the applicant(s) and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) the insurance does not provide benefits for any injury, illness, sickness, disease, or other physical, medical, mental or nervous disorder, condition or ailment that, with reasonable medical certainty, existed at the time of application or at any time during the time frame outlined in the contract prior to the effective date, whether or not previously manifested, symptomatic or known, diagnosed, treated, or disclosed to the Company prior to the effective date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom (a "pre-existing condition"), and that all charges and/or claims incurred for pre-existing conditions will be excluded from coverage as described in the Certificate of Insurance, which is incorporated by reference here and can be accessed at imglobal.com/sample-contracts, (iii) the subjects of insurance applied for are not intended or considered by the applicant(s), the Company or IMG to be resident, located, or expressly to be performed in any particular jurisdiction, and (iv) the Company, as carrier and underwriter of the insurance plan, is solely liable for the coverages and benefits to be provided under the insurance contract and IMG has no direct or independent liability under any insurance contract. **AUTHORIZATION FOR RELEASE OF INFORMATION.** The applicant(s) authorize any health plan, health care provider, health care professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to them or on their behalf, has any records or knowledge of their health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of them, and any non-medical information about them, to disclose their entire medical record, file, history, medications, and any other information concerning them and to give any and all such information to their agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries. **CERTIFICATION.** The applicant(s) hereby certify, represent and warrant that: (i) they have read the foregoing statements and any marketing materials and sample insurance contract which were made available upon request and prior to the application or that they have been read to them, and the applicant(s) understand them, (ii) they are eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) they are currently in good health and have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing or other medical condition which the applicant(s) foresee may require treatment during the insurance or for which the applicant(s) intend to claim under the insurance, and (iv) each applicant is not hospitalized, disabled, or HIV+. If signed as the legal representative of the applicant, the signer warrants their authority and capacity to so act and to bind each applicant. By acceptance of coverage and/or submission of any claim for benefits, each applicant ratifies the authority of the signer to so act and bind the applicant(s). **THE APPLICANT(S)** represent and warrant that under the insurance offered to the applicant(s), participation in the program is completely voluntary; the sole functions of the Sponsor with respect to the insurance is, without endorsing the program, to permit the insurer to publicize the program to applicant(s), to collect premiums and to remit them to the insurer; and the Sponsor receives no consideration in the form of cash or otherwise in connection with the insurance. The Sponsor acknowledges it must and agrees it will disclose certain material, including reports, statements, notices, and other documents, to applicant(s), beneficiaries and other specified individuals including but not limited to furnishing certain material to all applicant(s) covered under the insurance contract and beneficiaries receiving benefits under the insurance contract at stated times or if certain events occur; furnishing certain material to applicant(s) and beneficiaries upon their request; and making certain material available to applicant(s) and beneficiaries for inspection at reasonable times and places. The Sponsor represents and warrants it will use measures reasonably calculated to ensure actual, prompt receipt of the material by applicant(s), beneficiaries and other specified individuals. **IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA).** The applicant(s) have been informed that they, and any accompanying spouse and dependent(s), also may be subject to the requirements of the Affordable Care Act. The applicant(s) understand and agree that this insurance is not subject to, and does not provide benefits required by, PPACA. PPACA requires U.S. citizens, U.S. nationals, and resident aliens to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so. Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely the applicant(s') responsibility to determine if the insurance requirements are applicable to them, and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the applicant(s) may incur, for their failure to obtain coverage required by any applicable law including without limitation PPACA. The undersigned hereby arranges for insurance to be offered to the applicant(s). The applicant(s) have voluntarily authorized this action in writing, and the applicant(s) were also given the opportunity to make other arrangements to obtain insurance. These authorizations are kept on file by the undersigned and will be made available to the Company upon request. **E-CONSENT.** The applicant(s) wish to receive information and communicate electronically and prefer to use an e-mail address rather than regular mail. The applicant(s) agree IMG, its affiliates, and subsidiaries may provide each insured person with any communications in electronic format, and paper communications are not required, unless and until the applicant withdraws this consent. The applicant(s) unambiguously give consent to the transfer of personal data to entities established in a country outside the EU Member States. This consent is freely given, specific for the administration of coverage and benefits, and an informed indication of the applicant(s)' wishes. The applicant(s) acknowledge and understand the transfer is necessary for the performance of a contract, taken in response to their request, and necessary for the conclusion or performance of a contract concluded in their interest. The applicant(s) also agree it is their responsibility to provide IMG with true, accurate and complete e-mail address, contact, and other information related to the coverage, and to maintain and promptly update any changes in this information. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Responsible Officer *X*_______________________________	Date: ___/___/____ *(MM/DD/YYYY)*

IMG Producer Use Only

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

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

P.O. Box 88500
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.

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STUDENT HEALTH ADVANTAGE℠

IMG PRODUCER USE ONLY

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.

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