Outreach Travel Medical Insurance®

Short-term travel medical insurance for missionaries

WWW.IMGLOBAL.COM

IMG®

WHY IMG?

For more than 25 years, International Medical Group® (IMG®) has provided global benefits and assistance services to millions of members in almost every country. We're committed to being there with our members wherever they may be in the world, providing them Global Peace of Mind®. With 24/7 worldwide assistance and medical management services, multilingual claims administrators and highly trained customer service professionals, IMG delivers the insurance products international members need, backed by the services they want.

Global Family of Companies. IMG's global family of companies includes AkesoCare℠, Global Response Ltd., IMG-Stop Loss℠ and International Medical Administrators, Inc.

Service Without Obstacles. With a team of international, multilingual specialists, we are accustomed to working in multiple time zones, languages and currencies. Our global reach means we can work without barriers.

International Provider Access℠ (IPA). In addition to our expansive PPO network available for treatment received within the U.S., our proprietary IPA network of more than 17,000 accomplished physicians and facilities allows you to access quality care worldwide. Our direct billing arrangements can also ease the time and upfront expense at select providers.

Financial Stability. Our globally recognized underwriters, A-rated Sirius International Insurance Corporation (publ) and certain underwriters at Lloyd's, offer the financial security and reputation demanded by international consumers.

Accessible Technology. Log on to the secure, 24-hour online portal, MyIMG℠, to submit and view your claims, manage your account, search for providers, Live Chat with representatives and more.

International Emergency Care. When you're away from home and a medical emergency occurs, you may not be able to wait for regular business hours. With our on-site medical staff, you have 24-hour access to highly qualified coordinators of emergency medical services and international treatment.

WHY OUTREACH TRAVEL?

International travel can quickly turn into a frightening situation if you're not prepared for a medical emergency. Most travelers assume they will be covered by their standard medical plan, but that isn't the case. While traditional plans may offer adequate domestic coverage, they are not designed for international travel. Without even realizing it, you may be putting your health at risk.

Don't let your medical coverage be an uncertainty. Travel with one of IMG's two Outreach Travel Medical Insurance® plans so you can spend more time enjoying your international experience and less time worrying about medical coverage.

- Outreach International® provides coverage for U.S. citizens traveling outside of the U.S., with coverage for brief returns to the U.S.
- Outreach America® provides coverage for non-U.S. citizens traveling outside of their home country.

Both plans are available for individuals and families for a minimum of five days up to a maximum of two years, and offer a complete package of international benefits.
A separate Group Outreach plan is available for groups of five or more who are traveling outside of their home country as well as outside of the U.S. Group Outreach has no daily minimum requirement and the daily rate is the same for every member of the group, regardless of their age.

ADDITIONAL WORLD-CLASS SERVICES

- ***My*IMG℠**

Service at your fingertips — that's what My*IMG* provides. My*IMG* is a proprietary online service located at **myimg.imglobal.com** that provides you information and tools to manage your IMG accounts anytime, anywhere. Our service centers in the U.S. and Europe are available to assist with emergencies 24 hours a day, and through My*IMG* you have immediate access to important tools and resources. Some features include:

- » Submission and management of claims
- » Access to Explanations of Benefits (EOBs)
- » Initiate pre-certification
- » Access Customer Care via Live Chat, email or telephone
- » Locate a provider
- » Recommend a provider/facility
- » Obtain ID cards and other insurance documents

- **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.*

SCHEDULE OF BENEFITS

The following is a summary schedule of benefits for eligible medical expenses.
Benefits are subject to maximums, deductible and coinsurance, unless otherwise noted.

Maximum Limits options	$50,000, $100,000, $500,000, $1,000,000, $2,000,000 (U.S. citizens only)
Individual Deductible options	$0, $100, $250, $500, $1,000, $2,500
Coinsurance - for treatment received outside of the U.S.	No Coinsurance (0%)
Coinsurance - for treatment received within the U.S.	In the PPO Network - 10% of eligible expenses up to $5,000, then 0% Out of the PPO Network - 20% of eligible expenses up to $5,000, then 0%
Continuation of Treatment Period	Six months per injury or illness
Incidental Home Country Coverage	Up to 14 days
End of Trip Home Country Coverage	One month for every five months of travel coverage purchased, up to a maximum of two months. (Individual plan only)
Hospital Room and Board	Average semi-private room rate up to the maximum limit. Includes nursing service.
Intensive Care	Up to the maximum limit
Surgery	Up to the maximum limit
Physician Visits	Up to the maximum limit
Diagnostic Procedures	Up to the maximum limit
Prescription Medication	Up to the maximum limit
Home Nursing Care	Up to the maximum limit
Local Ambulance Expense	Up to the maximum limit
Emergency Room	Up to the maximum limit. Additional $250 deductible if not admitted as an inpatient.
Dental Emergency	Up to maximum limit for treatment due to an accident. $100 maximum limit for treatment of unexpected pain to sound natural teeth.

SCHEDULE OF BENEFITS (CONTINUED)

Emergency Medical Evacuation	Up to $500,000 lifetime maximum (independent of the maximum limit). Not subject to deductible.
Emergency Reunion	Up to $50,000 lifetime maximum
Return of Mortal Remains or Cremation/Burial	Up to $50,000 for return of mortal remains or $5,000 for cremation/burial. Not subject to deductible.
Return of Minor Children	Up to $50,000. Not subject to deductible.
Political Evacuation	Up to $10,000. Not subject to deductible.
Natural Disaster	Up to $100 per day and five days for accommodations. Not subject to deductible.
Terrorism	Up to $50,000 lifetime maximum. Not subject to deductible.
Sudden and Unexpected Recurrence of a Pre-Existing Condition - Medical (for U.S. citizens only)	Up to age 65 with primary health plan: URC up to maximum limit. Up to age 65 without primary health plan: $20,000 lifetime maximum. Age 65+: $2,500 lifetime maximum.
Sudden and Unexpected Recurrence of a Pre-existing Condition - Emergency Medical Evacuation (for U.S. citizens only)	Up to age 65: $25,000 maximum limit
Hospital Indemnity	Up to $100 per overnight (up to a maximum of 10 overnights). Not subject to deductible.
Common Carrier Accidental Death	$50,000 per insured person and $250,000 maximum limit per lifetime and per family. Not subject to deductible.
Accidental Death & Dismemberment	$25,000 principal sum. Not subject to deductible.
Identity Theft Assistance	Up to $500. Not subject to deductible.
Trip Interruption	Up to $5,000. Not subject to deductible.
Lost Luggage	Up to $50 per item; maximum of $250. Not subject to deductible.

OPTIONAL COVERAGE

Outreach Travel Medical Insurance offers several optional coverages. You may review and choose any from the following list that meet your needs. To apply, simply add in the appropriate information and premiums, as outlined in the application, into the calculation for the total premium due. Please note: With the exception of the Enhanced AD&D Rider and the Chaperone/Faculty Leader Replacement Riders, optional riders apply to all individuals listed on the Application.

Adventure Sports Rider *(available to Insureds through age 64)*	Age 0 - 49 50 - 59 60 - 64	Lifetime Maximum $50,000 $30,000 $15,000
Enhanced AD&D Rider *(available to the primary Insured on individual plans only)*	Up to an additional $400,000	
Citizenship Return Rider	Up to the maximum limit (U.S. citizens have a 60-day maximum)	
Evacuation Plus Rider *(available to Insureds up to age 65 on individual plans only)*	Non-life-threatening medical evacuation: Up to a maximum of $25,000. Natural disaster evacuation: Up to a maximum of $5,000.	
Chaperone/Faculty Leader Replacement Rider *(available on group plans only)*	Up to $3,000 for round-trip economy airline ticket	

ELIGIBILITY

Outreach Travel Medical Insurance is available for U.S. citizens and permanent residents traveling outside of the United States with coverage for brief returns to the U.S., and for non-U.S. citizens traveling outside of their home country. For those under 65 years of age and visiting the U.S., your initial Period of Coverage must begin within six months of arrival in the U.S. For those 65 years of age and older, it must begin within 30 days of arrival. These requirements will be waived with proof of previous valid international medical coverage. Prior U.S. domestic health care coverage does not meet this eligibility requirement. Please provide the name of your international insurance carrier on the Application. If you are not in the U.S. at the time of application, please indicate your expected date of arrival on your Application Form.

ENROLLMENT

To apply, simply complete and return the Application. If you are applying as a family, you may include yourself, your spouse and dependents on one Application. If you have dependents who are 18 years of age or older, you must complete a separate application for those individuals. If approved, you will receive a fulfillment kit, which includes an identification card, declaration of insurance and a Certificate Wording containing a complete description of benefits, exclusions and terms of the plan.

RENEWAL AND EXTENSIONS

Subject to the terms of the plan, Outreach Travel Medical Insurance can be extended for a minimum of five days up to a 365-day period, until reaching a maximum of 24 continuous months. Prior to the end of each period of coverage purchased, you will receive renewal information. You have the option to renew online or you may complete a paper renewal form. Each insured person must only satisfy one deductible and coinsurance within each 12-month period of coverage.

IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA): *This insurance is not subject to and does not provide benefits required by PPACA. As of January 1, 2014, PPACA requires U.S. citizens, U.S. nationals and certain U.S. residents 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, extend 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 an insured person's sole and exclusive responsibility to determine the insurance requirements applicable to them, and the Company and IMG shall have no liability whatsoever, including for any penalties a person may incur, for failure to obtain coverage required by any applicable law including, without limitation, PPACA. For information on whether PPACA applies to you or whether you are eligible to purchase Outreach Travel Medical Insurance, please see IMG's Frequently Asked Questions at www.imglobal.com/en/client-resources/PPACA-FAQ.aspx.*

Outreach Travel Medical Insurance

Your No. 1 choice for worry-free travel.

Outreach Travel Medical Insurance®

Producer Contact Information

Crossborder Services LLC
Five Greentree Center, Suite 104
Route 73
Marlton, NJ 08053
Phone: 877-340-7910
info@americanvisitorinsurance.com
https://www.americanvisitorinsurance.com

TM

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.

+1.317.655.4500 www.imglobal.com insurance@imglobal.com

Version 0117

OUTREACH GROUP APPLICATION

(For groups of five or more)

To Enroll

1. Complete all sections and sign application (Front and back - please print)
2. Please make check or money order payable to IMG and enclose in envelope with signed application form
3. Mail, fax or email to: International Medical Group, Inc., 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 #/ Passport #	Date of Departure *(month/day/year)*	Date of Return *(month/day/year)*	Total # of Days *(month/day/year)*
☐1						
☐2						
☐3						
☐4						
☐5						

(attach additional sheets, if necessary)

☐ 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 DEDUCTIBLE OPTION

CIRCLE ONE:
Select one option and one deductible for the entire group. The maximum benefit for ages 70-79 is always limited to $100,000 regardless of what maximum benefit the group selects, and the premium will be the same for all ages based on the table below.

Daily Rates	Deductibles		
	☐ $0	☐ $100	☐ $250
☐ **Option 1**: $100,000 Max	$2.25	$2.00	$1.80
☐ **Option 2**: $250,000 Max	$2.50	$2.20	$2.00
☐ **Option 3**: $1,000,000 Max	$2.75	$2.45	$2.20

3 PLAN PREMIUM

BASE PLAN		ADDITIONAL COVERAGE OPTIONS	
Total # of days for all travelers	_____	**Adventure Sports Rider** *(enter .20 if applicable)*	_____
Daily Rate *(from section 2)*	x _____	**Chaperone Rider** *(enter .10 if applicable)*	+ _____
Premium	= _____	**Total Rider Factor(s)**	= _____
Total Rider Factor *(From Additional Coverage Options)*	x1. _____		
$20 Optional Express Mail	+ _____		
Total Premium	= _____		

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

4 SPONSORING ORGANIZATION

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 applicant currently located in Florida? ☐ Yes ☐ No *(Determines applicable surplus lines tax and will not affect coverage)*	Group Name:
Requested Effective Date: ___/___/___ *(month/day/year)*	Earliest Date of Departure: ___/___/___ *(month/day/year)* Requested Expiration Date: ___/___/___ *(month/day/year)*
Purpose of Trip & Program:	Destinations:

OUTREACH GROUP APPLICATION

(For groups of five or more)

5 PAYMENT METHOD

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ 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. 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.

Card #:	Expiration Date: ___/___/___ *(month/day/year)*	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 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 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) on 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: ___/___/___ *(month/day/year)*

IMG Producer Use Only			
Producer Number:	Name:		
Email:	Phone Number:		
Address:	City:	State:	Postal Code:

OUTREACH INDIVIDUAL APPLICATION

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

1 PRIMARY APPLICANT INFORMATION

☐ Male ☐ Female	First Name:	Last Name:	Middle:
Government Issued ID Number:		Country of Citizenship:	
Country of Residence:	Home Country:	Destination Country:	

2 FULFILLMENT AND INFORMATION DELIVERY METHOD

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

☐ **For mail fulfillment kit, and renewal information** *(if applicable)*: **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 plan and maximum limit. Check one plan and one option:

☐ Outreach America for non-U.S. citizens:	☐ $50,000 ☐ $100,000 ☐ $500,000 ☐ $1 Million
☐ Outreach International for U.S. citizens:	☐ $50,000 ☐ $100,000 ☐ $500,000 ☐ $1 Million ☐ $2 Million

Select additional coverage option *(optional)*:

☐ Citizenship Return Rider:

If you are a U.S. citizen and elect this rider, have you resided outside of the U.S. continuously for the past 6 months? ☐Yes ☐No

Do you have a current health plan in force? ☐Yes ☐No ***If you answered No to either question, you are ineligible for this rider.***

Requested Effective Date: ___/___/___ *(month/day/year)*	Date of departure from your Home Country: ___/___/___ *(month/day/year)*
	Date of return to your Home Country: ___/___/___ *(month/day/year)*

Are you a non-U.S. citizen replacing current international coverage? ☐Yes ☐No

Current carrier:	Date of arrival in the U.S:	Expiration date of current coverage:

4 PREMIUM CALCULATION

Names of Persons to be insured: *Please attach additional sheet for more children*		Date of Birth *(month/day/year)*	Monthly Rate	# of Months Travel Coverage	Total	Daily Rate	# of Days	Total
Applicant		___/___/___	_____ x _____ = _____			_____ x _____ = _____		
Spouse		___/___/___	_____ x _____ = _____			_____ x _____ = _____		
Child 1		___/___/___	_____ x _____ = _____			_____ x _____ = _____		
Child 2		___/___/___	_____ x _____ = _____			_____ x _____ = _____		
		TOTAL	**(A)** _____		**(B)** _____			**(C)** _____

5 DEDUCTIBLE OPTION

CIRCLE ONE :
Select one deductible by circling it, then enter the applicable rate factor amount in the premium calculation box in Section 7 **(D)**

Deductible	$0	$100	$250	$500	$1,000	$2,500
Rate Factor	1.25	1.10	1.00	.90	.80	.70

6 END OF TRIP HOME COUNTRY COVERAGE *(optional)*

One month for every five months of consecutive coverage up to a maximum of two months of End of Trip Home Country Coverage

This will be added as additional months of coverage to your planned travel period and will begin upon the date of return to your home country

Monthly Rate Total (A)	# of Months Home Country Coverage	Total Home Country Coverage Premium
_____	X _____	= _____
Total		**(E)**

APPLICATION FORM CONTINUED ON BACK

OUTREACH INDIVIDUAL APPLICATION

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

7 PLAN PREMIUM

BASE PLAN

(B) Monthly premium total *(from B in Section 4)*	
(C) Daily premium total *(from C in Section 4)*	
(E) End of Trip Home Country Coverage premium total *(from E in Section 6)*	
B + **C** + **E** =	
(D) Deductible rate factor *(see Section 5)*	x
(F) Base premium	

ADDITIONAL COVERAGE OPTIONS

Adventure Sports Rider *(enter .20 if applicable)*	
Citizenship Return Rider *(enter .05 if applicable)*	+
(G) Total Rider Factor	=

Enhanced AD&D Rider

(To purchase, please complete the following calculation)

____ # of months x ____ Rate = ____ **(H)**

Evacuation Plus Rider

(To purchase, please complete the following calculation)

____ # of months x ____ # of Insureds x $45.00 = ____ **(I)**

TOTAL PREMIUM

Enter the amount from **(F)**	
Enter the amount from **(G)** to the right of the **1.**	x **1.** =
Enter the amount from **(H)**	+
Enter the amount from **(I)**	+
Optional express mail $20	+
TOTAL AMOUNT DUE	=

IMG PRODUCER USE ONLY

Producer #:		
Name:		
Address:		
City:	State:	Zip:
Phone:		
Email:		

8 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 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 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. On 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: ___/___/___ *(month/day/year)*	Phone:

9 PAYMENT METHOD

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ 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: ___/___/___ *(month/day/year)*	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.

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