



long-term worldwide medical insurance for international students and scholars



Secure, Reliable Medical Insurance

As an international scholar or student, the thrill of studying outside of your home country 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 should be enjoyable and gratifying. Maintaining the ability to be flexible and responsive, International Medical Group® (IMG®) has developed Student Health AdvantageSM, an international medical plan designed to specifically meet the needs of international students and scholars involved in long-term educational 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 and peace of mind should be too.

Student Health AdvantageSM

- » Designed to meet U.S. student visa requirements
- » Coverage for individuals or groups of two or more participants and their dependents
- » Maternity coverage
- » Mental & Nervous Disorders coverage
- » Intercollegiate/Interscholastic/Intramural or Club Sports coverage
- » International emergency care

Custom Products and 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 more than a million 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. We maintain IMG Europe Ltd. to provide the same world-class services abroad, with the added benefits of similar time-zones and swift delivery. At IMG, we're with you, providing you Global Peace of Mind®.

MyIMGSM

Service at your fingertips anytime, anywhere - that's what MyIMG provides. MyIMG is our proprietary online service that allows you to access information and manage your IMG accounts, 24 hours a day, seven days a week, from anywhere in the world. Some features include:

- » Explanation of benefits statements
- » Obtain certificate documents
- » Locate a provider
- » Claim status
- » Access ID cards
- » Initiate Precertification
- » Live chat with IMG



Global Peace of Mind®

SHA Summary of Benefits - Standard Plan

Maximum Limit	Student- \$500,000 period of coverage Dependent- \$100,000 period of coverage
Per Illness/Injury Maximum	Student- \$300,000 Dependent- \$100,000
Deductible	\$100 per Illness/Injury Student Health Center: \$5
Coinsurance	Outside the US & Canada: No coinsurance In PPO Network or Student Health Center within U.S. or Canada: No coinsurance Out of PPO Network if within U.S. or Canada: 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	URC
Maternity	Subject to Special Maternity Pre-certification requirements If incurred Outside of US/Canada: 100% eligible medical expenses to maximum limit If incurred In US/Canada PPO Provider: 80% eligible medical expenses to maximum limit If incurred in US/Canada NON PPO Provider: 60% eligible medical expenses to maximum limit
Routine Newborn Care	\$750 maximum per period of coverage
Emergency Room Injury	URC
Emergency Room Illness resulting in hospitalization	Up to maximum limit
Emergency Room Illness without In-patient Admission	URC; Subject to additional \$250 deductible
Mental & Nervous Disorders	Out-patient- \$50 per day; \$500 lifetime maximum In-patient- URC up to \$10,000 lifetime maximum Student Health Center Treatment - \$0
Prescription Drugs	In-patient URC Out-patient- 50% of actual charges
Physical Therapy	URC- limit 1 visit per day
Local Ambulance	Per Injury- up to \$350 \$350 per illness only if admitted as In-patient
Dental	Injury due to covered accident- \$500 maximum Sudden & Unexpected Pain to natural teeth- \$350 maximum
Eligible Medical Expenses	URC
Emergency Medical Evacuation	\$500,000 lifetime maximum
Emergency Reunion	\$50,000 lifetime maximum
Return of Mortal Remains	\$50,000 maximum
Political Evacuation	\$10,000 lifetime maximum
Intercollegiate/Interscholastic/ Intramural or Club Sports	\$5,000 maximum per Injury/Illness
Incidental Trip Coverage	Up to a cumulative 2 weeks
Pre-existing Conditions	Charges excluded until after 12 months of continuous coverage
Terrorism	\$50,000 lifetime maximum
AD&D	Student- \$25,000 principal sum
	Spouse- \$10,000 principal sum
	Dependent Child- \$5,000 principal sum
	Accident Dismemberment percentage of principal sum
Treatment Period	60 day minimum

SHA Summary of Benefits - Platinum Plan

Maximum Limit	Student - \$1,000,000 period of coverage Dependent - \$100,000 period of coverage
Per Illness/Injury Maximum	Student- \$500,000 Dependent- \$100,000
Deductible	For treatment received outside the US & Canada: \$25 per illness or injury For treatment received inside the U.S./Canada: PPO Provider: \$25 per illness or injury Non-PPO Provider: \$50 per illness or injury Student Health Center: \$5
Coinsurance	Outside the US & Canada: No coinsurance In PPO Network or Student Health Center within U.S. or Canada: No coinsurance Out of PPO Network if within U.S. or Canada: 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	URC
Maternity	Subject to Special Maternity Pre-certification requirements, same as any other Illness.
Routine Newborn Care	\$750 maximum per period of coverage
Emergency Room Injury	URC
Emergency Room Illness resulting in hospitalization	Up to Maximum Limit
Emergency Room Illness without In-patient Admission	URC; Subject to additional \$250 deductible
Mental & Nervous Disorders	Outpatient- \$50 per day; \$500 lifetime maximum Inpatient- URC up to \$10,000 lifetime maximum Student Health Center Treatment - \$0
Prescription Drugs	In-patient URC Out-patient- 50% of actual charges
Physical Therapy	URC- limit 1 visit per day
Local Ambulance	Per Injury- up to \$750 \$750 per illness only if admitted as In-patient
Dental	Injury due to covered Accident- \$500 maximum Sudden & Unexpected Pain to natural teeth- \$350 maximum
Eligible Medical Expenses	URC
Emergency Medical Evacuation	\$500,000 lifetime maximum
Emergency Reunion	\$50,000 lifetime maximum
Return of Mortal Remains	\$50,000 maximum
Political Evacuation	\$10,000 lifetime maximum
Intercollegiate/Interscholastic/Intramural or Club Sports	\$5,000 maximum per Injury/Illness
Incidental Trip Coverage	Up to a cumulative 2 weeks
Pre-existing Conditions	Charges excluded until after 6 months of continuous coverage
Terrorism	\$50,000 lifetime maximum
AD&D	Student- \$25,000 principal sum
	Spouse- \$10,000 principal sum
	Dependent Child- \$5,000 principal sum
	Accident Dismemberment percentage of principal sum
Treatment Period	60 day minimum

SHA Premium Rates

SHA Standard rates 2015

Individual Monthly Rates

U.S. Citizens			
Age	Student	Spouse	Dep Child
31 days to 18	\$55	\$352	\$65
19-23	\$61	\$352	\$65
24-30	\$80	\$386	\$65
31-40	\$121	\$514	\$65
41-50	\$197	\$528	\$65
51-64	\$262	\$514	\$65

Non U.S. Citizens			
Age	Student	Spouse	Dep Child
31 days to 18	\$69	\$405	\$86
19-23	\$92	\$405	\$86
24-30	\$106	\$448	\$86
31-40	\$190	\$596	\$86
41-50	\$311	\$616	\$86
51-64	\$415	\$596	\$86

Group Monthly Rates

U.S. Citizens			
Age	Student	Spouse	Dep Child
31 days to 18	\$47	\$301	\$57
19-23	\$52	\$301	\$57
24-30	\$68	\$328	\$57
31-40	\$103	\$438	\$57
41-50	\$167	\$450	\$57
51-64	\$223	\$438	\$57

Non U.S. Citizens			
Age	Student	Spouse	Dep Child
31 days to 18	\$59	\$346	\$73
19-23	\$78	\$346	\$73
24-30	\$90	\$382	\$73
31-40	\$162	\$508	\$73
41-50	\$265	\$524	\$73
51-64	\$353	\$508	\$73

SHA Platinum rates 2015

Individual Monthly Rates

U.S. Citizens			
Age	Student	Spouse	Dep Child
31 days to 18	\$88	\$516	\$95
19-23	\$97	\$516	\$95
24-30	\$128	\$565	\$95
31-40	\$193	\$753	\$95
41-50	\$314	\$773	\$95
51-64	\$417	\$753	\$95

Non U.S. Citizens			
Age	Student	Spouse	Dep Child
31 days to 18	\$111	\$594	\$126
19-23	\$146	\$594	\$126
24-30	\$169	\$656	\$126
31-40	\$303	\$873	\$126
41-50	\$496	\$902	\$126
51-64	\$662	\$873	\$126

Group Monthly Rates

U.S. Citizens			
Age	Student	Spouse	Dep Child
31 days to 18	\$72	\$423	\$78
19-23	\$80	\$423	\$78
24-30	\$105	\$463	\$78
31-40	\$158	\$618	\$78
41-50	\$258	\$634	\$78
51-64	\$342	\$618	\$78

Non U.S. Citizens			
Age	Student	Spouse	Dep Child
31 days to 18	\$91	\$487	\$104
19-23	\$120	\$487	\$104
24-30	\$139	\$538	\$104
31-40	\$249	\$716	\$104
41-50	\$407	\$740	\$104
51-64	\$543	\$716	\$104

New premium rates per Insured Person effective January 1, 2015 for eligible individuals whose applications are approved by IMG. IMG reserves the right to assess the most current rates at the time of the effective date in the event these rates expire, are modified, or are replaced. Rates include premium tax where applicable.

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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.

Age	Lifetime Maximum
31 days - 49	\$50,000
50 - 59	\$30,000
60 - 64	\$15,000

Maternity & Pre-Existing Condition Rider (Standard Plan Only):

The Maternity & Pre-Existing Condition Rider is available for eligible participants. Under this rider, eligible medical expenses for pre-natal care, delivery, post-natal care, and care of newborns can be covered after the insured has maintained coverage continuously for 10 months and the pregnancy is a result of natural insemination. Eligible medical expenses relating to a pre-existing condition can be covered after the insured has maintained coverage continuously for 6 months.

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SHA Plan Information

Conditions of Coverage:

1) Coverage and benefits are subject to the deductible limits, and coinsurance, and all terms of the Certificate of Insurance and Master Policy. **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. **6)** Claims must be presented to IMG for payment within ninety (90) days from the date the claim was incurred.

Eligibility

To be eligible to apply to the Student Health Advantage plan, you must:

- » Be a full-time student or scholar, the spouse of the full-time student or scholar, or a dependent traveling with the full-time student or scholar
- » Reside outside the country of residence for the purpose of pursuing international educational activities including college course work, research, or teaching for a temporary period of time.
- » Be physically and legally residing in host country with the intent to reside there for at least 30 days on the effective date and at renewal
- » Not be hospitalized, disabled, or HIV+ on the initial effective date.

Renewal of Coverage:

Eligible insureds whose initial coverage is at least 3 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.

Quality Guarantee:

Your satisfaction is very important to IMG. If you are not pleased with this product for any reason, you may submit a written request, within 5 days from the initial effective date, for cancellation and refund of your premium. If you do not have any claims filed with IMG, you may cancel your plan after the review period; however, the following conditions will apply:

1. You will be required to pay a \$50 cancellation fee.
2. Only full month premiums will be considered for refunds.

For example, if you choose to cancel your coverage two months and two weeks prior to the date your coverage ends, IMG will only consider the two full months for a refund. If you have filed claims, your premium is non-refundable.

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 spouse 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 home country
3. The date requested on your Application

Fulfillment Kits:

IMG processes applications in a quick, timely manner. Once processing is complete, IMG will mail and/or email the fulfillment kit(s) to the address/email listed in the Application. The fulfillment kit(s) will include an IMG Identification Card(s), IMG contact numbers, Claim Forms and the insurance certificate providing a complete description of the rights and benefits under the contract. For your convenience, you will get emailed 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.

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-alien 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. Please note that it is solely your responsibility to determine if PPACA is applicable to you, and the Company and IMG have no liability whatsoever, including for any penalties that you may incur, for your failure to obtain required PPACA compliant coverage.

SHA Claims Procedure

Precertification:

Certain treatment and supplies including hospital admission, in-patient or out-patient 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 Identification Card prior to admittance 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%. 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, 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 www.imglobal.com. Simply look for the Precertification option. You will be asked to provide the required information, which can then be submitted electronically. Once we have received all required information and medical records, our utilization management and review team will review the information provided and normally responds to the insured person or the provider within 2 business days. Please note that this online service will only initiate the process for treatment and supplies outlined in the contract, and it should not be used to request pre-certification 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.
2. Eligible expenses that have not yet been paid by the insured person may, at the option of IMG, be paid either to the insured person or directly to the provider.

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

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SHA Services

Akeso Care Management® (ACM®)

The ability to access quality health care 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 ACM, an on-site specialized division devoted entirely to medical management.

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

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



From routine medical care to complex case management, from check-ups to emergency medical evacuations, ACM 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.

Locating a Provider

With the Student Health Advantage Plan you may seek treatment while outside your home country with the hospital or doctor of your choice. When seeking treatment in the U.S., you have access to Preferred Provider Organizations (PPO), which are separately organized networks of hundreds of thousands of established, highly qualified health care physicians and many well recognized hospitals in the U.S. You can quickly search the network through MyIMG. Additionally, to help you locate health care providers outside the U.S., IMG provides its online International Provider AccessSM (IPA), a database of over 17,000 providers.

Our goal is to provide quality medical coverage wherever you may be while outside your home country. The PPO and our IPA enable us to do just that, and our online directories put the information at your fingertips - anytime, anywhere. Simply visit: **www.imglobal.com**.

Universal Rx Pharmacy Discount Savings

This is a discount savings program available to every insured in Student Health Advantage. This program allows card holders 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 discount program is not insurance. It is purely a discount program available to insureds in Student Health Advantage. Use of the discount card does not guarantee that medication is covered or will be reimbursed under the insurance plan.

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Indianapolis, IN 46208-0509 USA
For marketing questions, please call 1.866.368.3724
For all other inquiries, please call 1.800.628.4664 or 1.317.655.4500
Fax: 1.317.655.4505
Email: insurance@imglobal.com
www.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 (publ), rated A (excellent) by A.M. Best and A- by Standard & Poor's (at the time of printing).
Sirius International is a White Mountains Re company.

This invitation to inquire allows eligible applicants an opportunity to inquire further 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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IMG Producer Use Only

Student Health Advantage - Group Application

1.	Participants applying for coverage	Country of Citizenship & Country of Residence	Date of Birth	Government Issued ID Number	Participant's requested Effective date and Expiration date if different than group	# of Coverage Months	Premium Rate	# of Months Multiplied by Rate
<input type="checkbox"/> 1	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			
<input type="checkbox"/> 2	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			
<input type="checkbox"/> 3	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			
<input type="checkbox"/> 4	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			
<input type="checkbox"/> 5	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			

(attach additional sheets if necessary)

SUBTOTAL A: _____

2. Optional Coverages

Enter .20 to select the Adventure Sports Rider _____

Enter .70 to select the Six Month Pre-Existing Condition Rider + _____

(B) Total Rider Premium factor = _____ (B)

Enter this amount in Section 3.

3. Premium Calculation

_____ X 1. _____ + _____ = _____

Subtotal A (B) Rider Premium Factor \$20 Express Mail if requested TOTAL AMOUNT DUE

If the monthly payment option is requested, one month's premium must be submitted with the application. Monthly invoices will be sent thereafter.

Select the Plan Option: ☐ Standard ☐ Platinum

IMG Producer Use Only

Producer# _____

GA# _____

Name _____

Address _____

City, State, Zip _____

Phone: _____

Email: _____

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

To Enroll -

1. Complete all sections and sign Application
2. If paying by check or money order, please make payable to IMG and enclose in envelope with signed Application
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

Sponsoring Organization _____

Mailing Address _____

City/State/Zip _____

Phone _____ Fax _____

Government Issued ID Number _____

Responsible Officer Contact Name _____

Send Confirmation of Coverage and communications to the following Email : _____

If the address above is in Florida, is the sponsoring organization currently located in Florida? *(Determines applicable surplus lines tax and will not affect coverage)*

☐ Yes ☐ No

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

Requested Effective Date _____

Earliest Date of Departure _____

Requested Expiration Date _____

Purpose of Trip & Program _____

Destinations _____

Payment Method ☐ Check (To IMG) ☐ Wire ☐ Money Order (To IMG) ☐ JCB
☐ MasterCard ☐ Visa ☐ American Express ☐ Discover
eCheck (ACH) available online

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 _____

Cardholder Name _____

Authorized Signature _____

Cardholder's Phone & Email _____

Cardholder's Billing Address _____

1. Subscription. The Sponsoring Organization (Sponsor) represents and warrants it is the authorized agent of the participants and hereby applies and subscribes, for and on behalf of participants listed on the Application to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for the Student Health Advantage Program 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 agent and plan administrator, International Medical Group, Inc. (IMG). The Sponsor on behalf of itself and the participants understand and agree: (i) the insurance applied for is not general health insurance, but is intended for the participants' use in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) coverage is not renewable, (iii) the Sponsor must pay premiums for the entire period of coverage applied for, and no coverage will be effective until this application has been accepted in writing by the Company or by IMG on its behalf, (iv) 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 (v) by submission of this application and/or any future claim for benefits, the Sponsor on behalf of itself and the participants purposefully initiates and takes advantage of the privilege of conducting business with the Company in Indiana, through IMG as its managing general underwriter and plan administrator and 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 this insurance will be in Marion County, Indiana, for which the Sponsor on behalf of itself and the participants hereby expressly consents. Indiana surplus lines law shall govern all rights and claims raised under the Certificate of Insurance.

2. Acknowledgment. The Sponsor on behalf of itself and the participants understands and agrees that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of the applicants, (ii) this 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 12 months prior to the effective date of the insurance, whether or not previously manifested, symptomatic or known, diagnosed, treated, or disclosed to the Company prior to the effective date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom. (a "pre-existing condition"), and that all charges and/or claims incurred for pre-existing conditions will be excluded from coverage under the insurance, (iii) the subjects of insurance applied for are not intended or considered by the Sponsor, the participants, the Company or IMG to be resident, located, or to be performed in any particular state of the United States, 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.

3. Authorization for Release of Information. The Sponsor on behalf of each participant 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 the participant or on the participant's behalf, has any records or knowledge of the participant's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the participant, and any non-medical information about the participant, to disclose the participant's entire medical record, file, history, medications, and any other information concerning the participant and to give any and all such information to the participant's agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

4. Certification. The Sponsor on behalf of itself and the participants hereby certifies, represents and warrants that 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, and they understand the foregoing statements, and that each participant listed: (i) is eligible to participate in the insurance program applied for, and (ii) is currently in good health and has not been diagnosed with, sought consultation or been treated for, and has not experienced manifestation or symptoms of and does not suffer from any pre-existing or other medical condition which he/she foresees may require treatment during this insurance or for which he/she intends to claim under this insurance. As the legal representative of the Sponsor and each participant, the undersigned warrants his/her authority and capacity to so act and to bind the Sponsor and such participants. By acceptance of coverage and/or submission of any claim for benefits, each participant ratifies and affirms the authority of the signer and Sponsor to so act and bind the participant.

5. The Sponsor represents and warrants that under the insurance offered to the participants, 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 participants, 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 participants, beneficiaries and other specified individuals including but not limited to furnishing certain material to all participants 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 participants and beneficiaries upon their request; and making certain material available to participants 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 participants, beneficiaries and other specified individuals.

6. 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 Sponsor on behalf of itself and the participants 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) my 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) I understand that it is solely my responsibility to determine if PPACA is applicable to me, and the Company and IMG shall have no liability whatsoever, including for any penalties that any insured may incur, for a failure to obtain required or compliant coverage.

The Sponsor hereby arranges for insurance to be offered to the participants, the participants have voluntarily authorized this action in writing, and the participants 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.

7. The Sponsor on behalf of itself and the participants hereby certify, represent, and warrant that they have read, or have had read to them, all statements on this application. The Sponsor on behalf of itself and the participants represent that the responses are true, complete and correctly recorded; and that all travelers listed on this application are medically able to travel on the date this program is purchased. The Sponsor on behalf of itself and the participants understand and agree that subject to acceptance of this application and payment of the total amount due, coverage will begin at 12:01 a.m. on the day after this completed application is received and approved. The Sponsor on behalf of itself and the participants understand that if premium is returned unpaid for any reason, coverage becomes null and void. The Sponsor on behalf of itself and the participants acknowledge and understand that if not completely satisfied after receiving the insurance contract, the insured person may request cancellation of the insurance retroactive to the effective date by sending a written request to the Company within the review period outlined in the insurance contract, and thereby receive a refund of premium paid. The Sponsor on behalf of itself and the participants wish to receive information and communicate electronically, and prefer to use email rather than regular mail. The Sponsor on behalf of itself and the participants agree IMG may provide the recipient with any communications in electronic format, and IMG is not required to send paper communications, unless and until the participant withdraws this consent. The Sponsor on behalf of itself and the participants also agree it is the participant's 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.

Signature of Responsible Officer

Date

Student Health Advantage - Individual Application

1. Complete all sections and sign the Application.
2. If paying by check or money order, please make payable to IMG and enclose in envelope with signed Application.
3. Mail, fax or email completed Application to:

International Medical Group, Inc.

P.O. Box 88509
Indianapolis, Indiana
46208-0509 USA

Fax: 1.317.655.4505

Email: insurance@imglobal.com

Please Print: ☐ Male ☐ Female

Primary Applicant's Name: Mr. / Mrs. / Ms. **Last:** _____ **First:** _____ **Middle:** _____

Mailing Address: _____

Country of Citizenship: _____ **Country of Residence:** _____

Destination Country: _____ **Phone:** _____

Send Confirmation of Coverage and communications to the following:

Email: _____

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

If mailing address above is in Florida, is the applicant currently located in Florida? ☐ Yes ☐ No

(Determines applicable surplus lines tax and will not affect coverage.)

Requested effective date of coverage: _____ **Government Issued ID Number:** _____

Beneficiary:

Name: First: _____ Last: _____

Relationship: _____

1. Select the area of coverage

- ☐ **Non-U.S. citizens - Worldwide coverage except country of residence**
☐ **U.S. citizens - Worldwide coverage except U.S.**

2. Select the plan option

- ☐ **Standard** ☐ **Platinum**

3. Names of individuals applying for coverage:

Insured Name(s)	Date of Birth	Monthly Premium Rate
Primary Applicant _____	_____	_____
Spouse _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____
		Subtotal A _____

4. Premium calculation

Subtotal A	_____
# of Months	x _____
Estimated Monthly Premium	= _____
Adventure Sports Rider (multiply by 1.20 if requested)	x _____
Estimated Premium	= _____
Express Mail (add \$20 if requested)	+ _____
TOTAL AMOUNT DUE =	_____

IMG Producer Use Only

Producer# _____
GA# _____
Name _____
Address _____
City, State, Zip _____
Phone: _____
Email: _____

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0115

Payment Method ☐ Check (To IMG) ☐ Money Order (To IMG) ☐ Wire

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover ☐ JCB

eCheck (ACH) available online

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. 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 _____

Cardholder Name _____

Authorized Signature _____

Cardholder Phone & Email _____

Cardholder Billing Address _____

SUBSCRIPTION I (we) hereby apply and subscribe to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for Student Health Advantage 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). I (we) understand and agree: (i) the insurance applied for is not general health insurance, but is intended for my (our) use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) I (we) must pay premiums for the entire period of coverage in advance, and no coverage will be effective until 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) by submission of this application and/or any future claim for benefits I (we) purposefully initiate and take advantage of the privilege of conducting business with the Company in Indiana, through IMG as its managing general underwriter and plan administrator, and 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 this insurance will be in Marion County, Indiana, for which applicant(s) hereby consent(s). I (we) consent and agree that Indiana surplus lines law shall govern all rights and claims arising under the Certificate of Insurance.

ACKNOWLEDGEMENT I (we) understand and agree that: (i) the insurance producer/agent/broker soliciting, assigned to or assisting with this Application is the representative of applicant(s), (ii) this 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 12 months prior to the effective date of the insurance, whether or not previously manifested, symptomatic or known, diagnosed, treated, or disclosed to the Company prior to the effective date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom (a "pre-existing condition"), and that all charges and/or claims incurred for pre-existing conditions will be excluded from coverage under this insurance, (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 state of the United States, 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.

AUTHORIZATION FOR RELEASE OF INFORMATION I (we) 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 me or on my behalf, has any records or knowledge of my health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to disclose my entire medical record, file, history, medications, and any other information concerning me and to give any and all such information to my agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

CERTIFICATION I (we) hereby certify, represent and warrant that : (i) I (we) 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 me (us), and I (we) understand them, (ii) I am (we are) eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) I am (we 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 I (we) foresee may require treatment during this insurance or for which I (we) intend to claim under this insurance. If signed as the legal representative of the applicant, the signer warrants their authority and capacity to so act and to bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind applicant.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) I 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) my 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) I understand that it is solely my responsibility to determine if PPACA is applicable to me and the Company and IMG shall have no liability whatsoever, including for any penalties that any insured may incur, for a failure to obtain required or compliant coverage.

CERTIFICATION I (we) hereby certify, represent, and warrant that I (we) have read, or have had read to me (us), all statements on this application. I (we) represent that the responses are true, complete and correctly recorded; and that all travelers listed on this application are medically able to travel on the date this program is purchased. I (we) understand and agree that subject to your acceptance of this application and payment of the total amount due, coverage will begin at 12:01 a.m. on the day after this completed application is received and approved. I (we) understand that if premium is returned unpaid for any reason, coverage becomes null and void. I acknowledge and understand that if not completely satisfied after receiving the insurance contract, the insured person may request cancellation of the insurance retroactive to the effective date by sending a written request to the Company within the review period outlined in the insurance contract, and thereby receive a refund of premium paid. I wish to receive information and communicate electronically, and prefer to use my email address rather than regular mail. I agree IMG may provide me with any communications in electronic format, and IMG is not required to send paper communications to me, unless and until I withdraw this consent. I also agree it is my 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.

Signature of Primary Applicant or Legal Representative (Required)

Date: _____

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