

**APPLICATION FOR
GROUP INSURANCE**



PROSPECTIVE CERTIFICATE HOLDER (EMPLOYER)

| | | |
|--|-------------------|---|
| NAME | | |
| ADDRESS | | |
| CITY | STATE | ZIP CODE |
| COUNTRY | | |
| ACCOUNT CONTACT | | |
| PHONE NUMBER | FAX NUMBER | EMAIL ADDRESS |
| REQUESTED EFFECTIVE DATE (DAY/MONTH/YEAR) | | AMOUNT OF DEPOSIT WITH APPLICATION |
| | | \$ |

EMPLOYEE WAITING PERIOD FOR FUTURE EMPLOYEES
 FIRST OF THE BILLING MONTH FOLLOWING _____ (NUMBER) DAYS OF FULL-TIME EMPLOYMENT

EMPLOYER CONTRIBUTION _____ % OF ELIGIBLE EMPLOYEE PREMIUM
 _____ % OF DEPENDENT PREMIUM

ELIGIBLE EMPLOYEES TOTAL NUMBER OF EMPLOYEES _____
 TOTAL NUMBER OF ELIGIBLE EMPLOYEES _____
 TOTAL NUMBER OF EMPLOYEES APPLYING FOR COVERAGE _____

BENEFITS

On behalf of the Employer applicant named above as the prospective Certificate Holder, Employer hereby applies to the Global Medical Services Group Insurance Trust, Indianapolis, Indiana, for the following coverages and benefits:

| | | | | |
|----------------------------------|------------------------------|-----------------------------|---|---------------------------|
| MEDICAL | OPTION NUMBER _____ | DEDUCTIBLE \$ _____ | FAMILY LIMIT _____ | LIFETIME MAXIMUM \$ _____ |
| PRESCRIPTION DRUG BENEFIT | <input type="checkbox"/> YES | <input type="checkbox"/> NO | OPTION LETTER _____ | |
| DENTAL | <input type="checkbox"/> YES | <input type="checkbox"/> NO | OPTION NUMBER _____ | |
| LIFE & AD&D | <input type="checkbox"/> YES | <input type="checkbox"/> NO | (required on groups less than 20 lives) | |
| DAILY HOSPITAL INDEMNITY | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | |

Please make deposit check payable to: **International Medical Group, Inc.** International Medical Group®, Inc. (IMG®) is the managing general underwriter and plan administrator for the carrier, Sirius International Insurance Corporation (publ) (the Company).

Enclosed is payment of 1/12th of the estimated annual premium as deposit. Employer understands that no coverage shall be effective unless and until notified in writing by International Medical Group, Inc. that Employer's application has been accepted by IMG for and on behalf of the Company. Employer understands that any such acceptance is at the sole discretion of IMG. If Employer's application is accepted, the enclosed deposit will be applied toward payment of the first monthly premium. If Employer's application is not accepted, IMG's and the Company's sole obligation will be to return the deposit to Employer.

Employer understands that, as an employer employing persons in foreign jurisdictions, Employer may be subject to foreign laws with respect to the provision of medical benefits and/or the insurance of those benefits. Employer understands and agrees that neither the Company nor IMG have investigated whether or how the purchase of this insurance complies with the laws of any foreign jurisdiction. Employer further understands and agrees that Employer is solely responsible for compliance with all applicable foreign laws.

Applicant Signature _____ Date _____

Printed Name: _____ Title/Position: _____

Agent Signature _____ Date _____

Agent Name _____ Agent Number _____