

GLOBAL MEDICAL INSURANCESM

New Business Rates through 5/31/2003



Global Medical InsuranceSM New Business Rates through 5/31/2003 (Includes 2 ½% surplus lines tax.)

Annual Premiums (more deductible options can be found on the back of this page)

Please select your deductible carefully, as you will be unable to select a lower deductible when you renew your coverage.

Deductibles AGE	US\$250		US\$500		US\$1,000	
	Male	Female	Male	Female	Male	Female
14 days to 9 years**	First 2 Free Then 450*		First 2 Free Then 380*		First 2 Free Then 290*	
10-18**	490	490	400	400	310	310
19 - 24	1,075	1,785	925	1,585	720	1,140
25 - 29	1,175	1,950	1,025	1,750	795	1,260
30 - 34	1,230	2,140	1,080	1,940	840	1,445
35 - 39	1,345	2,290	1,195	2,090	925	1,600
40 - 44	1,505	1,875	1,330	1,675	1,030	1,300
45 - 49	1,645	2,045	1,470	1,845	1,140	1,435
50 - 54	2,000	2,220	1,800	2,020	1,400	1,575
55 - 59	2,532	2,532	2,321	2,321	1,812	1,812
60 - 64	3,493	3,293	3,230	3,030	2,705	2,505
65 - 69	7,213	6,291	6,950	6,027	6,425	5,500
70 - 74	Please contact IMG or your agent for premium information concerning this age bracket					
Modal Payment Factors *** Annual 1.00 Semi Annual .55 Quarterly .28						

***For semi-annual or quarterly payment modes, IMG will accept only Visa, MasterCard or American Express on a pre-authorized basis. Your credit card will be debited automatically on the due date(s) of your future premium installment(s).

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Rates are valid through 5/31/03

06/02

Please see reverse side for the \$2,500, \$5,000 and \$10,000 deductible options

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New Business Rates through 5/31/2003



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Annual Premiums *(more deductible options can be found on the back of this page)*

Please select your deductible carefully, as you will not be able to select a lower deductible when you renew your coverage.

Deductibles AGE	US\$2,500		US\$5,000		US\$10,000	
	Male	Female	Male	Female	Male	Female
14 days to 9 years**	First 2 Free Then 260*		First 2 Free Then 250*		First 2 Free Then 220*	
10-18**	280	280	270	270	240	240

*The first two Dependent Children between the ages of 14 days to 9 years are free **only when both parents or guardians** are insured under the Global Medical Insurance plan. **Dependent child rates are **only available when at least one parent or guardian** is insured under the Global Medical Insurance plan. Children applying with no parent or guardian insured by Global Medical Insurance must use the Male 19-24 rates.

19 - 24	635	1,010	520	830	410	650
25 - 29	700	1,115	575	910	450	710
30 - 34	745	1,280	610	1,050	480	820
35 - 39	820	1,415	670	1,135	525	890
40 - 44	915	1,155	745	945	590	740
45 - 49	1,010	1,270	825	980	650	770
50 - 54	1,275	1,430	1,045	1,170	820	920
55 - 59	1,644	1,644	1,345	1,345	1,050	1,050
60 - 64	2,469	2,284	2,048	1,812	1,681	1,497
65 - 69	4,996	4,514	4,334	3,902	3,572	3,217
70 - 74	Please contact IMG or your agent for premium information concerning this age bracket					
Modal Payment Factors *** Annual 1.00 Semi Annual .55 Quarterly .28						

***For semi-annual or quarterly payment modes, IMG will accept only Visa, MasterCard or American Express on a pre-authorized basis. Your credit card will be debited automatically on the due date(s) of your future premium installment(s).

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Please see reverse side for the \$250, \$500 and \$1,000 deductible options

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Underwritten by: Sirius International Insurance Corporation (publ) (the "Company")
 Distributed and administered by: International Medical GroupSM, Inc. ("IMGSM")

Important Information Regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This insurance is not subject to certain portability access and renewal requirements of the Health Insurance Portability and Accountability Act of 1996. You should therefore read and review all of the coverage conditions and pre-existing condition exclusions carefully before purchasing coverage.

Important Information About this Application

U.S. Citizens: If you or any family member applying for coverage are located in the U.S. on the date of this application, the effective date of this insurance, if issued, will be the later of:

- The effective date requested on the application; or
- The date the insured person departs the U.S.; or
- The date the application is accepted by IMG and a certificate of insurance issued.

Non-U.S. Citizens: If you or any family member applying for coverage are located in the U.S. on the date of this application and do not plan to depart the U.S., an affidavit of eligibility must be completed. Your insurance agent/broker can assist you in this regard. A new affidavit of eligibility will be required at each renewal.

Special Instructions for All Applicants

[Note: Failure to provide complete information may delay processing.]

- In Section 1, print or type your name and the names of all other family members applying for coverage as you want them to appear on your identification card(s). Also, please provide the **complete address of your residence** outside the U.S., and any mail forwarding address.
- All Applications must be fully completed, signed and dated to be considered.** If any questions are answered "YES" in Section 3, you must include the name, address and telephone number of the attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. (Please use the space provided in Section 7, entitled "Medical Information," to provide this information. Please attach additional pages as necessary).
- Annual premiums may be paid by check or money order, or by Visa, MasterCard, or American Express credit cards. IMG will not accept checks or money orders for quarterly or semi-annual payment modes. These payment modes are only **accepted with pre-authorization to debit your credit card on the due date(s) of your future premium installment(s).** An optional \$25 fee may be paid in addition to the premium to have your insurance certificate express mailed to you after approval.

SECTION 1. Please complete for all Family Members

Please print your name as you would like it to appear on your Insurance ID card Name	Height	Weight	Date of Birth			Country of Citizenship	Passport or Social Security #
			Mth.	Day	Yr.		
A. Applicant <input type="checkbox"/> Male <input type="checkbox"/> Female			/	/			
B. Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female			/	/			
C. 1st Child (below age 19) <input type="checkbox"/> Male <input type="checkbox"/> Female			/	/			
D. 2nd Child (below age 19) <input type="checkbox"/> Male <input type="checkbox"/> Female			/	/			
E. 3rd Child (below age 19) <input type="checkbox"/> Male <input type="checkbox"/> Female			/	/			

**U.S. CITIZENS PLEASE COMPLETE THIS AREA
ADDRESS OF RESIDENCE OUTSIDE THE U.S.**

**NON-U.S. CITIZENS PLEASE COMPLETE THIS AREA
ADDRESS OF RESIDENCE OUTSIDE THE U.S.**

Street Address:	Street Address:
City:	City:
State, Country, Postal Code:	State, Country, Postal Code:
Telephone:	Telephone:
Fax:	Fax:
E-mail Address:	E-mail Address:
Date you did (or will) depart from the United States: / /	<i>Note: If the above address is not completed, an Affidavit of Eligibility form must be completed.</i>
Is your expected length of residence outside the U.S. at least 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mail forwarding address if different from above	Mail forwarding address if different from above
Street Address:	Street Address:
City:	City:
State, Country, Postal Code:	State, Country, Postal Code:
Telephone:	Telephone:
Fax:	Fax:
E-mail Address:	E-mail Address:

SECTION 2. Please answer all questions for the Applicant and for each Family Member applying for coverage

		Family member (Use letters from Section 1)
1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are you or any other applicant presently hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If any individual answered YES to any of the above three questions, they are not eligible for this insurance. Thank you for your interest.		
1. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancer during the past five-(5) years? If yes, please complete Section 7.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. If a Non-U.S. citizen, have you or any other applicant resided continuously in the U.S. for the last five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If any individual answered YES to any of the above two questions, they may not be eligible for this insurance.		

SECTION 3.

Questions 1 – 16, below, must be answered for the applicant and every family member included on this Application. For any question that has been answered “YES,” please identify the family member to whom the answer applies (using the letter that corresponds to the family member from Section 1), and provide complete details of the medical condition at issue in the space provided in Section 7 of this Application, including the name, address and telephone number of all attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG reserves the right to request additional medical information.

		Family Member (Use letters from Section 1)
1. During the last twelve (12) months, have you or any family member applying for coverage been diagnosed with any medical condition or received any treatment (including medications or consultations) for any medical, mental, physical or nervous condition? If yes, please complete Section 7.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Have you or any family member applying for coverage ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you or any family member applying for coverage ever suffered from, been treated for, or been told that you (they) have any diseases, conditions, illnesses, medical problems, disorders, sicknesses or other problems arising from, involving, or relating to any of the following:

3. Heart, Cardiac, Cardiovascular, or Circulatory Condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Blood Vessels, Arteries, Blood Pressure, or Anemia? (If yes, provide most recent blood pressure reading)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Migraines, Chronic Headaches or Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Diabetes? (If yes, please complete supplemental Diabetes Questionnaire)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Cancer, Tumor, Cyst, Polyp, Lump or Growth of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Liver, Stomach, Gall Bladder, Colon or Intestines?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Kidney or Prostate? (Including testing or examination of the Prostate Gland)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Lung, Respiratory System or Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Mental, Nervous or Neurological? Drug Abuse or Alcoholism?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Bone or Skeletal, including any disorder of the Knee, Hip, or Back?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Reproductive Systems, including Miscarriage, Complications of Pregnancy or Delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Do you or any family member applying for coverage currently use tobacco in any form, or have you or any family member used tobacco during the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Any other illness, injury or condition of any kind not stated above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Have you or any family member applying for coverage ever applied for or purchased insurance through IMG? If yes, please provide policy number and details:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SUBSCRIPTION I (we) hereby apply to the Global Medical Services Group Insurance Trust, c/o Union Federal Savings Bank, Indianapolis, IN. I understand and agree: (i) that any misrepresentation or omission contained herein will void the insurance certificate, and any and all claims and benefits thereunder will be forfeited and waived, (ii) that IMG and the Company will rely on the accuracy and completeness of the information provided herein, (iii) that no coverage will be effective until this Application has been duly accepted in writing by the Company, (iv) that no modification or waiver relating to this Application or the coverage applied for will be binding upon the Company unless approved in writing by an officer of the Company, and (v) that the Master Policy is issued in the United States, and is governed by its laws.

ACKNOWLEDGEMENT I understand and agree that any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that existed at or prior to the date I am (we are) accepted for coverage, including any subsequent, chronic or recurring complications or consequences associated therewith or arising therefrom (a “pre-existing condition”), whether or not previously manifested, diagnosed, treated, or disclosed herein, will be excluded from coverage for two years from the effective date, and thereafter will be limited to \$50,000 lifetime per person, with a maximum of \$5,000 per person per policy period.

CERTIFICATION I hereby certify, represent and warrant: (i) that I have read the above questions or they have been read to me, and I understand them, (ii) that my responses to the questions are true, accurate and complete in all respects, (iii) that I am (we are) currently in good health and, except for the conditions and other information disclosed herein, have not been diagnosed with, treated for, and do not suffer from any pre-existing condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance.

MEDICAL RELEASE I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or financial and employment status, to provide such information to IMG and/or the Company.

Signature of Applicant or Guardian	Date (Mo/Day/Yr.)	Signature of Spouse	Date (Mo/Day/Yr.)
X		X	

GLOBAL MEDICAL INSURANCE SM



SECTION 5. DEDUCTIBLE SELECTION AND PREMIUM CALCULATION

Deductible Selection and Payment Mode must be the same for all Family Members.

Check one Deductible: \$250 \$500 \$1,000 \$2,500 \$5,000 \$10,000

PREMIUM CALCULATION (Applications without payment of premium will not be approved)

Annual premiums may be paid by check or money order, or by Visa, MasterCard, or American Express credit cards. IMG will not accept checks or money orders for quarterly or semi-annual payment modes. These payment modes are only **accepted with pre-authorization to debit your credit card on the due date(s) of your future premium installment(s)**. An optional \$25 fee may be paid in addition to the premium to have your insurance certificate express mailed to you after approval.

Enter the **annual** Global Medical Insurance premium for each Family Member that corresponds to their age, gender and deductible.

Primary Insured \$ _____
 Spouse \$ _____
 1st Child \$ _____
 2nd Child \$ _____
 3rd Child \$ _____
GMI Subtotal A \$ _____

This section must be completed.

Optional Benefits

Basic Term Life Premium \$ 240 X = **B** \$ _____
of adults applying

Supplemental Term Life \$ 180 X = **C** \$ _____
of adults applying

Child Term Life \$ 100 X = **D** \$ _____
of children applying

Global Daily Indemnity \$ 100 X = **E** \$ _____
of family members applying

Subtotal (A+B+C+D+E) = F \$ _____

Total Premium Due

\$ _____ X _____ + \$ 25.00* = **G** \$ _____
Subtotal F Modal Factor Optional Express Mail* Premium Amount Due

Modal Factors: Annual = 1.00 Semi-Annual = .55 Quarterly = .28

*Optional \$25 Express mail - Certificate will be expressed mailed to you after approval

IF YOU CHOOSE EXPRESS MAIL - Please select the address where you would like your Certificate express mailed (as indicated in Section 1)

Address of residence Mail forwarding address

Other (no P.O. boxes please) _____

METHOD OF PAYMENT

Check (annual only) Money Order (annual only)
 MasterCard* Visa* American Express*
 (signature required for credit card)

Checks and money orders should be made payable to International Medical Group, Inc. All payments must be made in US dollars and drawn on a US bank at the time application for coverage is made. If paying by credit card, I authorize IMG to debit my Visa/MasterCard/American Express Account for the total amount due. In the event that I have chosen a modal factor less than 1.00, I hereby elect to pre-authorize future credit card payment installments for the balance of the policy period (12 months from the Effective Date), and hereby request and authorize IMG to charge my credit card periodically as payment installments become due for premiums. This authorization will remain in effect until revoked by me in writing, and until IMG actually receives notice of revocation. Coverage purchased by credit card is subject to validation and acceptance by credit card company. ***For any mode of payment other than annual, I hereby pre-authorize IMG to debit my credit card for the balance of the policy period for the proper premium installment amount(s) on the future due date(s) of the installment(s).**

Credit Card # _____

Exp. Date _____

Signature **X** _____

Name as it appears on card _____

Daytime Phone# (_____) _____

Billing Address _____

REQUESTED EFFECTIVE DATE: _____

(Must be within 30 days of signature. Coverage will in no event be effective until approved.)

SECTION 6. - AGENT USE ONLY

Agent Number #:		Agent Name:		
Company Name:		Address:		
City:		State:	Zip :	
Phone:		Fax:	E-Mail Address:	
(Agent Signature) X _____				
GA #:				

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Please Mail or Fax to: International Medical Group, 407 Fulton Street, Indianapolis, Indiana 46202-3684 USA
 Call direct (U.S) 317-655-4500 or toll free (in U.S.) 800-628-4664, Fax (U.S.) 317-655-4505 www.imglobal.com

