STUDENT HEALTH ADVANTAGE

gateway℠

LONG-TERM WORLDWIDE MEDICAL INSURANCE
FOR INTERNATIONAL STUDENTS AND SCHOLARS

WWW.IMGLOBAL.COM

IMG™

MERCER

Global Peace of Mind®

Hello. Hola. Hallo. Hej.

You can greet someone in a foreign country in many ways. When you travel, stay safe and secure by saying hello to Student Health Advantage℠, a one-of-a-kind international medical insurance plan that brings you Global Peace of Mind® when you're traveling abroad.

Secure, Reliable Medical Insurance

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

Student Health Advantage℠

- Designed to meet U.S. student, scholar and cultural exchange program visa requirements
- Coverage for individuals or groups of five or more participants and their dependents
- Mental & Nervous Disorders and Substance Abuse coverage
- Intercollegiate/Interscholastic/Intramural or Club Sports coverage
- Maternity coverage (Platinum only)
- International emergency care

How Does the Affordable Care Act (ACA) Affect My Coverage?

Non-U.S. Citizens: As non-resident aliens, international students, scholars, and people involved in cultural exchange programs on F, J, M and Q visas (and certain family members) are not subject to the individual mandate for their first five years in the U.S. All other J categories (teacher, trainee, work and travel, au pair, high school, etc.) are not subject to the individual mandate for two years (out of the past six). Since international students are not subject to the mandate, they are not required to purchase a plan that meets PPACA requirements and can purchase Student Health Advantage.

U.S. Citizens: Under ACA, all U.S. citizens, nationals and resident aliens are required to purchase minimum essential coverage (ACA compliant coverage), unless they are exempt. Exempt U.S. citizens include U.S. citizens who reside outside of the U.S. for 330 of any 365-day period, or have a tax home (main place of work or employment, or if you don't have a main place of work or employment, your main residence) in a foreign country, and is a bona fide resident of a foreign country.

Please note that this insurance is not subject to, and does not provide benefits required by, ACA. On January 1, 2014, ACA requires U.S. citizens, U.S. nationals and resident-aliens to obtain ACA compliant insurance coverage unless they are exempt from ACA (international students on F, J, M and Q visas (and certain family members of students) are not subject to the individual mandate for their first 5 years in the U.S. All other J categories - teacher, trainee, work and travel, au pair, high school, etc. - are not subject to the individual mandate for 2 years out of the past six). Penalties may be imposed on persons who are required to maintain ACA compliant coverage but do not do so. Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including ACA. Please note that it is solely your responsibility to determine if ACA is applicable to you and the Company and IMG shall have no liability whatsoever, including for any penalties that you may incur, for your failure to obtain required ACA compliant coverage. For information on whether ACA applies to you or whether you are eligible to purchase Student Health Advantage, please see IMG's Frequently Asked Questions at www.imglobal.com/en/client-resources/PPACA-FAQ.aspx. The materials available on this website are for informational purposes only and not for the purpose of providing legal advice. You should contact your attorney to obtain advice with respect to any particular issue or problem.

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 millions of people around the globe with customer service that's second to none. We provide on-site medical staff who are available 24 hours a day for emergencies, multilingual customer service professionals and dedicated claims administrators who process tens of thousands of claims each year from all over the world. At IMG, we're with you, providing you Global Peace of Mind®.

SHA Summary of Benefits - Standard Plan

Maximum Limit	Student- $500,000 per period of coverage Dependent- $100,000 per period of coverage
Per Illness or Injury Maximum	Student- $300,000 Dependent- $100,000
Deductible	$100 per illness or injury Student Health Center: $5 copay per visit
Coinsurance	Outside of the U.S.: No coinsurance In PPO Network or Student Health Center within the U.S.: No coinsurance Out of PPO Network if within the U.S.: 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
Emergency Room Injury	URC
Emergency Room Illness resulting in hospitalization	URC
Emergency Room Illness without Inpatient Admission	URC; Subject to additional $250 deductible
Mental & Nervous Disorders and Substance Abuse	Outpatient- $50 per day; $500 lifetime maximum Inpatient- URC up to $10,000 lifetime maximum Student Health Center Treatment - $0
Prescription Drugs	Inpatient URC Outpatient- 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 inpatient
Dental	Injury due to covered accident- $500 maximum per accident 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 and Repatriation	$10,000 lifetime maximum
Intercollegiate/Interscholastic/ Intramural or Club Sports	$5,000 maximum per injury or illness
Incidental Trip Coverage	Up to a cumulative 14 days
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
	Accidental dismemberment percentage of principal sum
Treatment Period	60 day minimum

SHA Summary of Benefits - Platinum Plan

Maximum Limit	Student - $1,000,000 per period of coverage Dependent - $100,000 per period of coverage
Per Illness or Injury Maximum	Student- $500,000 Dependent- $100,000
Deductible	For treatment received outside of the U.S.: $25 per illness or injury For treatment received within the U.S.: PPO Provider: $25 per illness or injury Non-PPO Provider: $50 per illness or injury Student Health Center: $5 copay per visit
Coinsurance	Outside of the U.S.: No coinsurance In PPO Network or Student Health Center within the U.S.: No coinsurance Out of PPO Network if within the U.S.: 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	Coinsurance: Outside of the U.S.: 100% of eligible expenses Within the U.S. PPO Network: 80% of eligible expenses Within the U.S. Out of PPO Network: 60% of eligible expenses
Routine Newborn Care	$750 maximum per period of coverage
Emergency Room Injury	URC
Emergency Room Illness resulting in hospitalization	URC
Emergency Room Illness without Inpatient Admission	URC; Subject to additional $250 deductible
Mental & Nervous Disorders and Substance Abuse	Outpatient- $50 per day; $500 lifetime maximum Inpatient- URC up to $10,000 lifetime maximum Student Health Center Treatment - $0
Prescription Drugs	Inpatient URC Outpatient- 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 inpatient
Dental	Injury due to covered accident- $500 maximum per accident 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 and Repatriation	$10,000 lifetime maximum
Intercollegiate/Interscholastic/Intramural or Club Sports	$5,000 maximum per injury or illness
Incidental Trip Coverage	Up to a cumulative 14 days
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
	Accidental dismemberment percentage of principal sum
Treatment Period	60 day minimum

SHA Premium Rates

SHA Standard rates 2016

Individual Monthly Rates

U.S. CITIZENS			
Age	Student	Spouse	Dep Child
31 days to 18	$52	$301	$62
19-23	$58	$301	$62
24-30	$76	$330	$62
31-40	$115	$439	$62
41-50	$187	$451	$62
51-64	$249	$439	$62

NON U.S. CITIZENS			
Age	Student	Spouse	Dep Child
31 days to 18	$66	$346	$82
19-23	$87	$346	$82
24-30	$101	$383	$82
31-40	$181	$510	$82
41-50	$295	$527	$82
51-64	$394	$510	$82

Group Monthly Rates

U.S. CITIZENS			
Age	Student	Spouse	Dep Child
31 days to 18	$45	$257	$54
19-23	$49	$257	$54
24-30	$65	$280	$54
31-40	$98	$374	$54
41-50	$159	$385	$54
51-64	$212	$374	$54

NON U.S. CITIZENS			
Age	Student	Spouse	Dep Child
31 days to 18	$56	$296	$69
19-23	$74	$296	$69
24-30	$86	$327	$69
31-40	$154	$434	$69
41-50	$252	$448	$69
51-64	$335	$434	$69

SHA Platinum rates 2016

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 June 1, 2016 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.

SHA Optional Riders

ADVENTURE SPORTS RIDER:

The Adventure Sports Rider is available for eligible participants. Certain activities designated as adventure sports can be covered up to the maximums listed below. Certain activities are never covered regardless of whether or not the Adventure Sports Rider is issued. For a list of activities which can be considered to be adventure sports, a sample rider can be provided upon request.
(Available to insureds through age 64)

AGE	LIFETIME MAXIMUM
31 days - 49	$50,000
50 - 59	$30,000
60 - 64	$15,000

SHA Plan Information

Conditions of Coverage:
1) Coverage and benefits are subject to the deductible limits, and coinsurance, and all terms of the Insurance Contract, which includes the Master Policy and all governing documents, as summarized in the Certificate of Insurance. **2)** Coverage under a Student Health Advantage plan is secondary to any other coverage. **3)** Coverage and benefits are for eligible medical expenses which are medically necessary and usual, reasonable and customary. **4)** Charges must be administered or ordered by a licensed physician. **5)** Charges must be incurred during the Period of Coverage. **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 home country 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.

Enrollment Process:
Before you begin your travel, simply apply online or fill out the Application and calculate the estimated premium for the time period you, your group, and/or your dependents will be traveling. Once you have completed the Application, return it to your insurance agent and/or IMG.

Eligible individuals listed on the Application and for whom premiums have been paid will be covered from the latest of the following dates:

1. The date IMG approves your completed Application and receives the appropriate premium
2. The date you depart from your 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), 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.

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 Precertification for emergency admissions, procedures, or evacuations.*

Claims Payment:
All benefits payable under Student Health Advantage are subject to the terms and conditions in the Certificate of Insurance. To make claim processing efficient, claims for eligible medical expenses may be paid in two ways:

1. Eligible expenses that have been paid by or on behalf of the insured person may be reimbursed by check directly to the insured person.
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 form can be submitted online at myimg.imglobal.com, or emailed to insurance@imglobal.com, or mailed to International Medical Group, P.O. Box 88500, Indianapolis, IN 46208-0500 USA. IMG may also be contacted by fax at 1.317.655.4505.

SHA Services

MyIMG℠
MyIMG is a proprietary online service located at myimg.imglobal.com that allows you to manage your IMG accounts, 24 hours a day, seven days a week, from anywhere in the world. Some features include:

- Submission and management of claims
- Access to Explanation of benefits (EOBs)
- Initiate Precertification
- Access Customer Care via Live Chat, email or telephone
- Locate and recommend a provider/ facility
- Obtain ID cards and other insurance documents

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 Access℠ (IPA), a database of over 17,000 providers.

Our goal is to provide quality medical coverage wherever you may be while outisde 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: **myimg.imglobal.com**.

Universal Rx Pharmacy Discount Savings
This discount savings program allows you to purchase prescriptions at one of over 35,000 participating pharmacies in the U.S. and receive the lower of 1) Universal Rx contract price or 2) the pharmacy regular retail price. This program is not insurance coverage; it is purely a discount program. **Akeso Care**

Akeso Care Management® (AkesoCare℠)
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 AkesoCare, an on-site specialized division devoted entirely to medical management.

urac
ACCREDITED
Health Utilization Management
Expires 05/01/2019

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. AkesoCare has international medical experience, providing services in more than 170 countries worldwide.

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

From routine medical care to complex case management, from check-ups to emergency medical evacuations, AkesoCare is there for you. They are committed to patient protection and empowerment, quality operations and provider compliance. This translates into better care for you - around the world, around the clock.

Student Health Advantage - Individual Application

1. Complete all sections and sign the application. *(Please print)*
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

Primary applicant's name: Mr. / Mrs. / Ms. **Last:** _____ **First:** _____ **Middle:** _____
Mailing address: _____
Country of citizenship: _____ **Country of residence:** _____
Destination country: _____ **Phone:** _____
☐ Male ☐ Female

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#: 57691
Name: MERCER HEALTH & BENEFITS
Address: 2960 North Meridian Street
City, State, Zip: Indianapolis IN 46208
Phone: 1-877-808-7434
Email:

Payment method: ☐ Check (To IMG) ☐ Money Order (To IMG) ☐ Wire

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover ☐ JCB

eCheck (ACH) available online or 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. 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:_____

_____

1. 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 raised under the Certificate of Insurance.

2. Acknowledgment 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.

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

4. 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.

5. 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 (*international students on F, J, M and Q visas, and certain family members of students, are not subject to the individual mandate for their first 5 years in the U.S. All other J categories - teacher, trainee, work and travel, au pair, high school, etc. - are not subject to the individual mandate for 2 years out of the past six*), (iii) penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so, and (iv) 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 your responsibility to determine if PPACA is applicable to you and the Company and IMG shall have no liability whatsoever, including for any penalties that you may incur, for your failure to obtain required PPACA compliant coverage.

6. 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 (we) 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 (we) wish to receive information and communicate electronically, and prefer to use my (our) email address rather than regular mail. I (we) agree IMG may provide me (us) with any communications in electronic format, and IMG is not required to send paper communications to me (us), unless and until I (we) withdraw this consent. I (we) also agree it is my (our) responsibility to provide IMG with true, accurate and complete e-mail address, contact, and other information related to my (our) coverage, and to maintain and promptly update any changes in this information.

Signature of Primary Applicant or Legal Representative *(required)*

_____

Date: _____

Student Health Advantage - Group Application *(For groups of five or more)*

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

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
☐1	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			
☐2	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			
☐3	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			
☐4	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			
☐5	Applicant Name & Email: Spouse: Child: Child:	CC: CR:			EF: EX:			

(attach additional sheets if necessary)

SUBTOTAL A: _____

2. Premium Calculation

_____ (Subtotal A) X 1. _____ (Enter .20 for the Adventure Sports Rider *if requested*) + _____ (Enter $20 for 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.

IMG PRODUCER USE ONLY

Producer#: 57691
Name: MERCER HEALTH & BENEFITS
Address: 2960 North Meridian Street
City, State, Zip: Indianapolis IN 46208
Phone: 1-877-808-7434
Email: _____

Select the Plan Option: ☐ Standard ☐ Platinum

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

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 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 has read and agrees 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 authorizes 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 (*international students on F, J, M and Q visas, and certain family members of students, are not subject to the individual mandate for their first 5 years in the U.S. All other J categories - teacher, trainee, work and travel, au pair, high school, etc. - are not subject to the individual mandate for 2 years out of the past six*), (iii) penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so, and (iv) 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 your responsibility to determine if PPACA is applicable to you and the Company and IMG shall have no liability whatsoever, including for any penalties that you may incur, for your failure to obtain required PPACA 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 certifies, represents, and warrants that they have read, or have had read to them, all statements on this application. The Sponsor on behalf of itself and the participants represents 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 understands and agrees 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 understands that if premium is returned unpaid for any reason, coverage becomes null and void. The Sponsor on behalf of itself and the participants acknowledges and understands 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 receives a refund of premium paid. The Sponsor on behalf of itself and the participants wishes to receive information and communicate electronically, and prefers to use email rather than regular mail. The Sponsor on behalf of itself and the participants agrees 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 agrees 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

P.O. Box 88509
2960 North Meridian Street, 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 seek information about the insurance offered and is limited to a brief description of any loss for which benefits may be payable. Benefits are offered as described in the insurance contract. Benefits are subject to all deductibles, coinsurance, provisions, terms, conditions, limitations, and exclusions in the insurance contract. The contract does contain a pre-existing condition exclusion and does not cover losses or expenses related to a pre-existing condition.

STUDENT HEALTH ADVANTAGE

IMG PRODUCER USE ONLY

MERCER HEALTH & BENEFITS, LLC
2960 North Meridian Street
Indianapolis, IN 46208
Phone: 1-877-808-7434
Fax: 1.317.655.4505
global@marshpm.com
http://www.gatewayplans.com

www.imglobal.com | 1.800.628.4664

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.