APPLICATION FORM

IMG Maestro is underwritten by International Medical Insurance Company, Ltd. (the "Company"). International Medical Group®, Inc. ("IMG®") is the Company's authorized agent and representative, and the Plan Administrator of the insurance contract.

MAESTRO℠
HARMONY IN HEALTHCARE

All applications must be fully completed, signed, and dated to be considered.

Please indicate the preferred language in which you wish to receive your contract and related documentation.
☐ *English* ☐ *Spanish*

SECTION 1. Please complete for all Family Members applying for coverage.

Name *(Please print your name below)*	Height	Weight	Date of Birth *DD/MM/YYYY*	Country of Citizenship	Government Issued ID Number
A. APPLICANT *(Last, First, Middle)* ☐ *Male* ☐ *Female*	☐ cm ☐ in	☐ kg ☐ lb			
B. SPOUSE *(Last, First, Middle)* ☐ *Male* ☐ *Female*	☐ cm ☐ in	☐ kg ☐ lb			
C. FIRST CHILD *(Below age 18 - Last, First, Middle)* ☐ *Male* ☐ *Female*	☐ cm ☐ in	☐ kg ☐ lb			
D. SECOND CHILD *(Below age 18 - Last, First, Middle)* ☐ *Male* ☐ *Female*	☐ cm ☐ in	☐ kg ☐ lb			
E. THIRD CHILD *(Below age 18 - Last, First, Middle)* ☐ *Male* ☐ *Female*	☐ cm ☐ in	☐ kg ☐ lb			

PRIMARY RESIDENCE ADDRESS

STREET ADDRESS	
CITY	STATE, COUNTRY, POSTAL CODE
TELEPHONE	FAX

Will each applicant be physically residing in a Latin American or Caribbean country with the intent to reside there for at least 6 of the next 12 months?
☐ Yes ☐ No
(If you answered "No" you are not eligible for coverage.)

Are you currently in Latin America or the Caribbean? ☐ Yes ☐ No
(If you answered "No" you must wait to apply until you are present within a country in this region.)

MAILING ADDRESS *(if different from above)*

STREET ADDRESS	
CITY	STATE, COUNTRY, POSTAL CODE

Email Contact Preference - At what email address would you like us to contact you after receiving the application and at renewal?

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

The following questions must be accurately answered for the applicant and every family member included on this Application. For any question answered "YES," please identify the family member to whom the answer applies (use the letter that corresponds to the family member from Section 1), and provide complete details of the condition in Section 3 of this Application, including the contact information for all provider(s), and information related to the treatment. IMG and the Company reserve the right to request additional information following review of the answers.

		IF YES, SHOW FAMILY MEMBER USING LETTERS FROM SECTION 1	
1.	Are you or any other applicant currently disabled or unable to perform any activity of daily living?	☐ Yes ☐ No	
2.	Are you or any other applicant presently hospitalized, or scheduled for or in need of or been advised that you should have hospitalization or surgery?	☐ Yes ☐ 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?	☐ Yes ☐ No	
4.	Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	☐ Yes ☐ No	
If any individuals answered Yes to any of the above four questions, he or she does not qualify for this insurance. Thank you for your interest.			
5.	Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please explain in Section 3.	☐ Yes ☐ No	
6.	Are you or any other applicant currently pregnant? If yes, please provide due date:	☐ Yes ☐ No	
7.	Do you participate in professional sports? If yes, which sport? (If yes, you must purchase Professional Sport Rider)	☐ Yes ☐ No	

Have you or any family member applying for coverage EVER experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:			
8.	Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 3, please complete the following: **a)** Date of most recent blood pressure reading?_____ **b)** Most recent blood pressure reading: _____AS/_____DS **c)** Medications taken (Types and Dosage)_____	☐ Yes ☐ No	
9.	Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including but not limited to anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	☐ Yes ☐ No	
10.	Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, in addition to Section 3, please complete the following: **a)** Diabetic Type: I_____ or II _____ **b)** Date diagnosed:_____ **c)** Controlled by diet only? Yes_____ No_____ **d)** Medications (Types and Dosage) _____ **e)** Date of most recent HbA1c Test?_____ **f)** Results of HbA1c Test (1 - 10)_____	☐ Yes ☐ No	
11.	Asthma or allergies? If yes, in addition to providing explanation in Section 3, please specify which one and complete the following: **a)** Date diagnosed:_____ **b)** Has hospitalization or emergency room treatment been required? If yes, describe and list date(s):_____ **c)** Please list known triggers:_____ **d)** Medications (Types and Dosage):_____ **e)** Frequency of attacks:_____	☐ Yes ☐ No	
12.	Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind?	☐ Yes ☐ No	
13.	Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	☐ Yes ☐ No	
14.	Kidney, urinary tract functions, kidney or bladder stones or infections?	☐ Yes ☐ No	
15.	Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	☐ Yes ☐ No	
16.	Mental, emotional and/or nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, ADD or ADHD, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?	☐ Yes ☐ No	

SECTION 2. *(continued)*

	IF YES, SHOW FAMILY MEMBER USING LETTERS FROM SECTION 1	
17. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	☐ Yes ☐ No	
18. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	☐ Yes ☐ No	
19. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, and/or disorders of the reproductive system or of menstruation, including but not limited to: vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus, and hormone replacement therapy?	☐ Yes ☐ No ☐ N/A	
20. For male applicants, disorders of the reproductive system, including but not limited to: prostate or elevated PSA level, or erectile dysfunction?	☐ Yes ☐ No ☐ N/A	
21. Congenital, genetic, hereditary or other birth condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	☐ Yes ☐ No	
22. Digestive system, stomach, colon, rectum or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, Crohn's Disease and/or diverticulitis?	☐ Yes ☐ No	
23. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	☐ Yes ☐ No	
24. Do you or any family member applying for coverage currently use or during the past five years have used tobacco in any form?	☐ Yes ☐ No	
25. Any other disease, medical problem, illness, injury or condition of any kind not listed above?	☐ Yes ☐ No	
26. During the last twelve (12) months, have you or any family member applying for coverage experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please explain in Section 3.	☐ Yes ☐ No	
27. Have you or any family member applying for coverage ever applied for or purchased insurance through IMG? (If yes, please provide certificate number, if any, and details.)	☐ Yes ☐ No	
28. Have you or any family member applying for coverage ever been rejected, canceled, rated or declined for coverage under any health, life or disability insurance policy? If yes, please explain in Section 3.	☐ Yes ☐ No	
29. During the last twelve (12) months, have you or any family member applying for coverage been covered under any health or medical insurance plan, including a government sponsored health care plan? If yes, please state the name and location of the insurance company, the policy/plan number, and the applicable dates of coverage.	☐ Yes ☐ No	
30. If yes to question #29, do you intend to continue being insured under your existing medical insurance plan?	☐ Yes ☐ No	

SECTION 2a. **Please list all prescribed and over the counter medications, and any treatment in the last twelve months for the Applicant and for each Family Member for whom it applies (use the corresponding letter(s) from Section 1). Please attach additional pages as necessary.**

FAMILY MEMBER *(use letters from Section 1)*	**Medications and Dosages**	**Conditions**	**Date(s) of Treatment**

FAMILY MEMBER *(use letters from Section 1)*	**Surgeries**	**Date(s) of Treatment**

SECTION 2a. *(continued)*

Primary Doctor's Details - The following information must be completed	
DOCTOR'S NAME	TELEPHONE
ADDRESS	
COUNTRY	POSTAL/ZIP CODE
DATE LAST SEEN:	REASON:

SECTION 3. Medical Information/Prior Insurance

For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the condition at issue, including the name, address and the telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treament, prognosis, and present course of treatment. ***Please attach additional pages as necessary.*** IMG and the Company reserve the right to request additional information prior to acceptance of Application.

FAMILY MEMBER *(use letters from Section 1)*	**Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)**	**Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone**	**Date(s) of Treatment**

If any family member applying for coverage has ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance contract (see Question 28), please explain below.

SUBSCRIPTION I (we) hereby apply to the Global Medical Services Group Insurance Trust, Hamilton, Bermuda, or its successor, for IMG Maestro℠ as offered by the Company on the date of its receipt hereof. I (we) understand and agree that: (i) no coverage will be effective until the required premium has been paid and this Application has been duly accepted in writing by the Company, (ii) 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, (iii) IMG and the Company will rely on the accuracy, truthfulness, and completeness of the information provided herein, (iv) any misrepresentation or omission contained herein will void the insurance certificate, and any and all claims and benefits thereunder will be forfeited and waived, (v) by submission of this Application and/or any future claim for benefits I (we) purposefully initiate and take advantage of the privilege of conducting business with the Company in Hamilton, Bermuda, through IMG as its selected agent and administrator, and (vi) the contract of insurance represented by the Master Policy and evidenced by the Certificate of Insurance shall be deemed issued and made in Hamilton, Bermuda, and sole and exclusive jurisdiction and venue for any legal proceeding relating to this insurance shall be in the courts in Hamilton, Bermuda, for which applicant(s) hereby consent(s). I (we) agree that Bermuda law shall govern all rights and claims arising under this insurance, understand and acknowledge that the laws of the country which I (we) incur medical expenses or maintain my (our) residence do not apply, and trial of any dispute shall be by the court as fact finder, without a jury.

ACKNOWLEDGMENT I (we) understand and agree that: (i) marketing materials and certificate wordings were available prior to application upon request, (ii) the insurance agent, broker, website, or other producer, if any, involved with respect to the solicitation of this Application is acting solely as my legal agent and representative and is representing my (our) personal interests, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of, the Company or IMG, (iii) any illness, injury, 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 prior to the effective date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, treated, or disclosed to the Company or IMG prior to the effective date, and including any and all chronic, subsequent or recurring complications or consequences related thereto or resulting or arising therefrom (a "pre-existing condition"), and on certain plan options, will be excluded from coverage for the time frame outlined in the insurance contract following the effective date (iv) any existing condition/diagnosis/illness that is not disclosed on my (our) application would never be covered under the insurance contract, (v) the contract of insurance applied for is not intended or considered by the applicant(s), the Company or IMG to be resident, located, or to be performed in any particular state of the United States, or any country, and (vi) the Company, as carrier and underwriter of the plan, is solely liable for the coverages and benefits to be provided thereunder, and IMG acts solely as agent for the Company and has no direct or independent liability under the Master Policy or any Certificate of Insurance.

CERTIFICATION I (we) hereby certify, represent and warrant to IMG and the Company that: (i) I (we) have read the questions contained in this Application or they have been read to me (us), and I (we) understand them, (ii) my (our) responses to the questions are true, accurate and complete in all respects as of the date hereof, and that I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto, (iii) I am (we are) currently in good health and, except for the conditions and other information disclosed herein, I (we) 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 in the future or for which I (we) intend to claim under this insurance, and (iv) if this Application is signed as legal representative or agent of the applicant, the signer warrants their authority and capacity to so act and 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 the applicant.

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 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 the Company, IMG, and their affiliates, and subsidiaries.

SATISFACTION GUARANTEE/REVIEW PERIOD It is understood I (we) will have 15 days from the effective date to review the Certificate of Insurance and all benefits, terms, conditions, limitations and exclusions of coverage. If not completely satisfied, I (we) may request cancellation of the insurance retroactive to the effective date by sending a written request to the Company within the review period, and thereby qualify to receive a refund of premium paid.

I (we) wish to receive information and communicate electronically, and prefer to use an email address rather than regular mail. I (we) agree IMG may provide each insured person with any communications in electronic format, and IMG is not required to send paper communications, 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 coverage, and to maintain and promptly update any changes in this information.

NOTE: Please check your bulk or junk email folder if you do not receive any communications regarding the application shortly after completing the application and paying the premium

IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA): This insurance is not subject to, and does not provide benefits required by, PPACA. On January 1, 2014, PPACA requires U.S. citizens, U.S. nationals and resident-aliens to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so. Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely 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.

Signature of Applicant, Guardian, or Proxy* *(Relationship to Applicant if signing as Guardian or Proxy)* **Date *(DD/MM/YYYY)***

Signature of Spouse **Date *(DD/MM/YYYY)***

**A parent or legal guardian's signature is required for any applicant under the age of eighteen (18).*

GLOBAL TERM LIFE INSURANCE[SM]

GLOBAL DAILY INDEMNITY[SM]

Underwritten by International Medical Insurance Company, Ltd. (IMIC). It is distributed, managed and administered, as agent for IMIC, by International Medical Group®, Inc. ("IMG®"). Global Term Life Insurance and Global Daily Indemnity are only available at the time of application for, and with the approval of coverage under the IMG Maestro plan.

SECTION 4. Please indicate the name of each Family Member applying for these optional plans

Name	Term Life Unit One	Term Life Unit Two	Indemnity Unit One	Indemnity Unit Two
A. APPLICANT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B. SPOUSE	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
C. FIRST CHILD	☐ Yes ☐ No	**NOT AVAILABLE**	☐ Yes ☐ No	☐ Yes ☐ No
D. SECOND CHILD	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
E. THIRD CHILD	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

Beneficiary Designation for Adult Applicants.

Note: default beneficiary for a Child Applicant is automatically the Adult Applicant(s). A separate sheet can be attached for more complex designations.

APPLICANT A

PRIMARY BENEFICIARY NAME RELATIONSHIP

CONTINGENT BENEFICIARY NAME RELATIONSHIP

APPLICANT B

PRIMARY BENEFICIARY NAME RELATIONSHIP

CONTINGENT BENEFICIARY NAME RELATIONSHIP

If accepted for the IMG Maestro plan, I (we) understand that I (we) may apply for Global Term Life Insurance and/or Global Daily Indemnity underwritten by International Medical Insurance Company. I (we) do hereby apply to the Global Life Insurance Services Group Insurance Trust, Bank of Bermuda, Hamilton, Bermuda, for Global Term Life Insurance and/or Global Daily Indemnity, as requested above. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorizations, and warranties from the foregoing Application for insurance, and understand and agree that the terms, conditions, restrictions and penalties thereof shall likewise apply hereto. If I (we) have also applied for the optional Global Daily Indemnity plan, I (we) understand that only overnight hospital stays eligible under my (our) IMG Maestro plan, excluding pregnancies, are covered. I (we) also understand: (i) there is an additional premium for Global Daily Indemnity, (ii) that in the event IMG or IMIC does not accept this Application, its sole obligation is to return the premium to the applicant, (iii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iv) that the Master Policy for Global Term Life Insurance and Global Daily Indemnity is issued in Bermuda and is governed by those laws.

Signature of Applicant, Guardian or Proxy	**Date *(DD/MM/YYYY)***	**Signature of Spouse**	**Date *(DD/MM/YYYY)***

SECTION 5. Deductible Selection and Premium Calculation.

Note: Plan Option, Deductible Selection, and Payment Mode must be the same for all family members.

Check one Plan Option: ☐ Vital ☐ Total ☐ Total Plus
Check one Deductible: ☐ $500/$1,000 ☐ $1,000/$2,000 ☐ $1,500/$3,000 ☐ $5,000 ☐ $10,000 ☐ $20,000
Check one Payment Mode: ☐ Annual = 1.00 ☐ Semi-Annual = 0.55 ☐ Quarterly = 0.28 ☐ Monthly = 0.10

Note: Choosing the semi-annual payment option (modal payment factor .55) results in total payments of 110% of the annual premium, choosing the quarterly payment option (modal payment factor .28) results in total payments of 112% of the annual premium, and choosing the monthly payment option (modal payment factor .10) results in total payments of 120% of the annual premium.

IMG will not accept checks, money orders or wire transfers for semi-annual, quarterly, or monthly payment modes, except for IMG Maestro Groups. **These payment modes are only accepted with authorization to debit your credit card or bank account on the due date(s) of your future premium installment(s).**

PREMIUM CALCULATION

Enter the ***annual*** IMG Maestro premium for each Family Member that corresponds to their age and deductible.

Application cannot be processed unless this section is completed.

Primary Applicant	$_____
Spouse	$_____
1st Child	$_____
2nd Child	$_____
3rd Child	$_____
IMG Maestro Subtotal	**$**_____

Optional Coverage

Term Life Unit One	$240 x_____ = # of adults applying	**A** $_____
Term Life Unit Two	$180 x_____ = # of adults applying	**B** $_____
Term Life Unit One - Child	$100 x_____ = # of children applying	**C** $_____
Daily Indemnity Unit One	$100 x_____ = # of family members applying	**D** $_____
Daily Indemnity Unit Two	$100 x_____ = # of family members applying	**E** $_____
Professional Sports Rider	$500 x_____ = # of family members applying	**F** $_____

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

Total Premium Calculation

$_____ (Subtotal) x _____ (Payment Mode) + _____ (Optional Express Mail *($25 additional fee)*) = **H $_____ Premium Amount Due**

Payment Factors: Annual=1.00 Semi-Annual=0.55 Quarterly=0.28 Monthly=0.10

COVERAGE DOCUMENTATION

In addition to receiving electronic communication I choose to select the following paper options:

☐ **Optional Express Mail ($25 additional fee)**
Please select which address in Section 1 where you would like the Certificate express mailed
☐ Residence Address ☐ Mailing Address
☐ Other (no P.O. boxes please) _____

☐ **Regular Mail option**
I do not mind the delays associated with receiving the initial communication via regular mail and prefer to receive a paper copy of the coverage verification letter and insurance contract to the mailing address listed in Section 1.

METHOD OF PAYMENT (Applications without payment of premium owed will not be approved)

☐ Check (annual only) ☐ Money Order (annual only)
☐ Wire (annual only) ☐ MasterCard ☐ Visa
☐ American Express ☐ Discover ☐ JCB

eCheck (ACH) available online

Checks and money orders should be made payable to International Medical Group, Inc. (IMG). For wire transfer information, please contact IMG. All payments must be made in U.S. dollars. 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.

Credit Card #_____

Exp. Date _____
(cannot be earlier than last premium installment due date)

Cardholder Name_____
_____

Cardholder Phone # (_____) _____

Cardholder Billing Address _____
_____

Authorized Signature X_____
(Authorized signature required for credit card payments)

REQUESTED EFFECTIVE DATE: _____
(Must be within 30 days after submission to IMG. Coverage cannot be effective until approved in writing by IMG or Company.)

SECTION 6. Insurance Producer Use Only

IMG PRODUCER NUMBER	PRODUCER NAME
COMPANY NAME	
ADDRESS	
CITY, STATE, ZIP	PHONE
FAX	EMAIL ADDRESS
WEBSITE	

IMPORTANT:

AS PRODUCER, I ACCEPT FULL RESPONSIBILITY FOR THE SUBMISSION OF THIS APPLICATION, THE ACCURACY OF ITS INFORMATION, AND SENDING ALL THE COLLECTED PREMIUMS . I DO NOT KNOW OF ANY INFORMATION OR CONDITION THAT HAS NOT BEEN DISCLOSED IN THIS APPLICATION WHICH WILL AFFECT THE INSURABILITY OR APPROVAL OF THE PROPOSED INSUREDS.

PRODUCER SIGNATURE

Please mail, email, or fax this application to:
Maestro Premiere Services
International Medical Group, Inc.
2960 North Meridian St.
Indianapolis, IN 46208 USA

Call direct: **+1 317-655-4500**
or **+1 305-409-1095**
Fax: **+1 317-655-4505**
Email: **imgmaestro@imglobal.com**
Web: **www.imgmaestro.com**

Any changes to information within this application or contact information should also be promptly directed to IMG.