

Disclaimer



Insurance can be effective only after the underwriting department receives and reviews your application with the legal department, which can take 3 to 5 business days.

Underwriting department and legal department are open during regular business hours from Monday through Friday.

By submitting this paper application, you acknowledge and agree that:

- Back dated applications are not possible.
- Insurance coverage is not guaranteed to be approved for every person that submits the application.
- You hold Insubuy and the writing agent (if any) harmless and relieve us from any liability because of this.

If the above terms are not acceptable to you, please do not submit the application.

If you need to purchase the insurance urgently, please call our office at +1 (866) INSUBUY or the writing agent to confirm, before sending the application.



Application for Group Insurance



Your GEO group insurance is underwritten and offered by Sirius International Insurance Corporation (the “Company”) and will be deemed issued and made in Hamilton, Bermuda, governed by Bermuda law, with sole and exclusive jurisdiction and venue for any legal proceeding relating to this insurance in Hamilton, Bermuda.

PROSPECTIVE PARTICIPATING ORGANIZATION (“APPLICANT”)		
Full Legal Name:		
Address:		
City:	State:	Postal/Zip Code:
Country:	EIN/ TIN:	Government Issued ID Number:
Authorized Representative:		
Telephone Number:	Fax Number:	Requested Effective Date: ___/___/___ (MM/DD/YYYY)
Fulfillment Option: <input type="checkbox"/> Email <input type="checkbox"/> Mail	Communications should be sent via E-mail to:	
MyIMG Group Administrator User ID (6 or more characters):		Amount of Premium Deposit: \$
<input type="checkbox"/>	I am an authorized representative of the group members and the group members agree to the processing of their personal information to provide the services they have purchased, including to administer claims, and to receive member communications, in accordance with IMG’s Privacy Policy.	
<input type="checkbox"/>	I am an authorized representative of the group members and the group members agree to receive relevant information and other communications from IMG about insurance coverages and service options. The group members understand that they can withdraw consent at any time.	

EMPLOYEE WAITING PERIOD FOR FUTURE EMPLOYEES
First of the Coverage Month Following _____ Days of Full-Time Employment <small>(number)</small>

EMPLOYER CONTRIBUTION	
_____ % of Employee Premium	_____ % of Dependent Premium

ELIGIBLE EMPLOYEES (Organization must have at least 2 employees enrolled to receive and maintain coverage under the contract)		
Number of Employees:	Number of Eligible Employees:	Number of Employees Applying for Coverage:

REQUESTED BENEFITS		
Medical Deductible: \$	Family Deductible Limit (2x or 3x):	Lifetime Maximum: \$
Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Option: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Life & AD&D: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(\$10,000 minimum required on groups less than 11 employees)</small>	Life & AD&D Amount: \$	
Daily Hospital Indemnity: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Life insurance required in order to purchase this benefit)</small>		

AUTHORIZATION

APPLICATION. The Participating Organization (Applicant), by its authorized representative, hereby applies for GEO insurance coverage as underwritten and offered by the Company and administered by the Company’s authorized representative and plan administrator, International Medical Group (IMG). The Applicant understands and agrees that: (i) the Applicant must pay premiums for the entire period of coverage in advance, and no coverage will be effective until the required premium has been paid and this application has been 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, and (iii) the Company relies on the accuracy, truthfulness, and completeness of the information provided in this form or previously provided to IMG or the Company in the GEO RFP. Any misrepresentation or omission contained herein or on the GEO Group RFP, will void the insurance and any and all claims and benefits thereunder will be forfeited and waived. Rates are based on your submitted census. International Medical Group reserves the right to adjust the rates from audit date back to effective date if any of the following changes occur or are discovered after the date of the proposal: Enrollment +/- 10%, Average Contract Size +/- 10%, Area Factor +/- 7.5%, Age/Sex Factor +/- 10%, Any Material Changes, Less than 100% of all eligible employees enroll in an employer sponsored plan, Less than 80% of all benefit eligible employees (including spousal waivers) enroll with International Medical Group. Please also note that plans do not include a provision for 4Q deductible carryover or deductible credit from prior carrier.

ACKNOWLEDGEMENT. The Applicant 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 applicant(s) and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) this insurance contains a number of exclusions from coverage, including an exclusion for pre-existing conditions, and a complete copy of the insurance contract, including all exclusions, can be accessed at imglobal.com/sample-contracts, (iii) the subjects of insurance applied for are not intended or considered by the Applicant, the Company or IMG to be resident, located, or expressly to be performed in any particular jurisdiction, 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 and IMG has no direct or independent liability under any insurance contract.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA). This insurance is intended for Participating Organizations with members on expatriate status (members who have a good faith belief that they will reside outside of their Home Country for at least six months during a plan year) and their Spouses and Dependents. This insurance is regulated by a foreign government, and is considered to be Minimum Essential Coverage under the U.S. Patient Protection and Affordable Care Act (PPACA) for each month when the member (i) is outside of the U.S. for at least one day of that month or (ii) is physically present in the U.S. for an entire month if the coverage provides health benefits within the U.S. while the member is on expatriate status. 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 the Applicant’s responsibility to determine the insurance requirements that are applicable to it and the Company and IMG shall have no liability whatsoever, including for any penalties that Applicant or any of its members may incur, for failure to obtain coverage required by any applicable law, including without limitation PPACA.

CERTIFICATION. The Applicant hereby certifies, represents and warrants that : (i) the Employees have read the foregoing statements and any marketing materials and a sample insurance contract that were made available upon request and prior to the application or that they have been read to the Employees, and the Employees understand them, (ii) the Employees are eligible to participate in the insurance program applied for, (iii) if signed as the legal representative of the Employee, the signer warrants their authority and capacity to so act and to bind the Employees. 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 Employees, and (iv) subject to Company’s acceptance of this application and payment of the total amount due, coverage will begin at 12:01 a.m. on the approved effective date. The Applicant understands that if premium is returned unpaid for any reason, coverage becomes null and void.

Authorized Representative Signature: X _____	Date: ____/____/____ (MM/DD/YYYY)
Printed Name:	Title/Position:
Producer Signature: X _____	Date: ____/____/____ (MM/DD/YYYY)
Printed Name:	