



Group Outreach Travel Medical InsuranceSM

Part A

Group Name: _____

Contact Name: _____

Address: _____

Telephone: _____

Fax Number: _____

IMG Agent # 20693

City: _____ State: _____ Zip: _____

E-Mail Address: _____

Part B

Name	Date of Birth	Date of Departure	Date of Return	Total # of days	Passport Number	Beneficiary	Destination*
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Part C

Method of Payment: VISA MasterCard American Express Check

*Group coverage not available in the U.S.

Credit Card Number: _____ Expiration Date: _____ Name on Credit Card: _____

Signature: _____

If paying by credit card, I authorize IMG[®] to bill my credit card for the total charge as specified in "Total Premium" below.

Premium per person per day (choose ONLY one option):

Option 1: \$2.00 \$100,000 Maximum
 \$250 deductible all options

Option 2: \$2.20 \$250,000 Maximum

Option 3: \$2.45 \$1,000,000 Maximum

*Minimum of 5 persons

**Up to Age 69 – Age 70 and above must use individual policy

Part D

$$\begin{array}{ccccccc}
 \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & = & \underline{\hspace{2cm}} \\
 \text{(# of Days)} & & \text{(Premium)} & & \text{(# in Group)} & & \text{(Total Premium – include total for additional pages)}
 \end{array}$$

OVERNIGHT
DELIVERY OPTION
 Add \$20.00

ALL PAYMENTS SHOULD BE MADE PAYABLE TO IMG