MCIS MULTICHOICE INSURANCE SERVICES, LLC

Telephone: **1-510-353-1180**

Email Address: **contact@multichoiceinsurance.com**

Web site: **www.multichoiceinsurance.com**

Thank You!
Your application was successful. Your credit card or applicable account has been charged 135.20 USD. Please print this page for your records. You will receive a fulfillment kit with your insurance documents and ID cards via email or mail. Please use your ID card to present to providers.

Print

CERTIFICATE NUMBER: PATAI81882934

Medical Coverage Information

Product	Patriot Travel Medical Insurance®
Product Type	Travel Medical
Application Type	0717
Maximum Limit	500,000.00 USD
Deductible	1,000.00 USD
Length of Coverage	1 Month(s)

Travel Eligibility Questions

Are you currently residing in your primary destination country?	Yes
You answered that your Primary Destination Country is the United States or one of its territories. Have you been in the U.S. or one of its Territories for more than 6 month(s)?	No

Primary Insured Information

Name	ahalya devi mandala
Date of Birth	04-May-1964
Gender	Female
Government Issued ID Number	R0604574
Country of Citizenship	India
Home Country	India
Primary Destination Country *For non-U.S. citizens, select U.S. if any of your destinations include the U.S.*	United States

Important Dates

Requested Coverage Effective Date	01-May-2018
Requested Expiration Date	31-May-2018 (Minimum length of coverage is 5 days)
Legal Expiration Date	01-Jun-2018 12:01 AM EST

Date of Departure from Home Country	19-Apr-2018
Date of Return to Home Country	29-Sep-2018
Date of Arrival in the U.S.	20-Apr-2018

Mailing Address

Name	AHALYA DEVI MANDALA
Address	1001 S Main St
Address 2	APT D210
City	Milpitas
County/Region	CA
State/Province	CA
Zip/Postal Code	95035
Country	United States
Telephone	9722730158
Mobile/Other Telephone	---
Fax	---
Email Address	rreddydev@gmail.com
Other Email Address	---

Names of Persons to be Insured and Base Medical Premium

First Name	Last Name	Age	Cost
ahalya devi	mandala	53	135.20 USD

Sub Total	135.20 USD
Total Premium	135.20 USD
Total Due Calculation	

Online Fulfillment	0.00 USD
Patriot America® Total Cost	135.20 USD
TOTAL DUE AT CHECKOUT	**135.20 USD**

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 Patriot Travel Medical Insurance as underwritten and offered by Sirius International Insurance Corporation (publ) (the Company) on the date of receipt hereof. I (we) understand and agree:(i) the insurance applied for is not general health insurance, but is intended for my (our) use 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 agent and administrator, and invoke the benefits and protections of its laws, 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 court action or administrative 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 law shall govern all rights and claims raised under this Certificate of Insurance.
MERCHANT LOCATION: International Medical Group's corporate headquarters is located at 2960 North Meridian Street Indianapolis, IN USA.

ACKNOWLEDGEMENT. The applicants understand and agree that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of applicants and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) the 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 time frame outlined in the contract prior to the effective date, 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 applicants, 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.

AUTHORIZATION FOR RELEASE OF INFORMATION. The applicants 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 them or on their behalf, has any records or knowledge of their health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of them, and any non-medical information about me, to disclose their entire medical record, file, history, medications, and any other information concerning them and to give any and all such information to their agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

CERTIFICATION. The applicants hereby certify, represent and warrant that : (i) 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 or that they have been read to them, and the applicants understand them, (ii) they are eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) they 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 the applicants foresee may require treatment during the insurance or for which the applicants intend to claim under the insurance, and (iv) each applicant is not hospitalized, disabled, or HIV+. If signed as the legal representative of the applicant, the signer warrants their authority and capacity to so act and to bind each applicant. By acceptance of coverage and/or submission of any claim for benefits, each applicant ratifies the authority of the signer to so act and bind the applicants.

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 the applicants' responsibility to determine the insurance requirements applicable to them and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the applicants may incur, for their failure to obtain coverage required by any applicable law including without limitation PPACA.

E CONSENT. The applicants wish to receive information and communicate electronically, and prefer to use an e-mail address rather than regular mail. The applicants agree IMG, its affiliates, and subsidiaries may provide each insured person with any communications in electronic format, and paper communications are not required, unless and until the applicant withdraws this consent. The applicants unambiguously give consent to the transfer of personal data to entities established in a country outside the EU Member States. This consent is freely given, specific for the administration of coverage and benefits, and an informed indication of the applicants' wishes. The applicants acknowledge and understand the transfer is necessary for the performance of a contract, taken in response to their request, and necessary for the conclusion or performance of a contract concluded in their interest. The applicants also agree it is their 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. 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.

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.

All applications must be fully completed, signed and dated to be considered. The application must be signed by the applicant, a guardian, or proxy. A guardian must be legally authorized to sign on behalf of an applicant, especially a minor. A guardian would include a parent. A guardian?s signature is required for any applicant under the age of sixteen (16). A Proxy is a person authorized by the applicant to act on their behalf.

A guardian or proxy that signs an application warrants their authority and capacity to sign for and bind the applicant. By accepting coverage and/or submitting a claim for benefits, the applicant ratifies the authority of the guardian or proxy to sign for and bind the applicant.

Signature of Applicant, Guardian, or Proxy (Required):

☑ By checking this box, I agree to have my credit card or applicable account charged 135.20 USD and I have read and agree to all terms, conditions, and other statements on this page.

ravinder r mandala

Date 30-Apr-2018