Beneficiary Designation Form

Please print legibly and complete ALL SECTIONS (front and back) of this application. Mail, fax, or email application by secure means only:
Address: International Medical Group, Travel Claims, PO Box 241853, Apple Valley, MN 55124
Call: 1.866.243.7524 or 1.317.655.9798; **Fax:** +1.317.927.6882
Email: customercare@imglobal.com
www.imglobal.com

Insured's Name *(Last, First, Middle)*:	
Policy Number:	Insured's Date of Birth: ___/___/___ *(MM/ DD/YYYY)*

Subject to the terms and conditions of the insurance contract, applicable laws, and any rights of a valid assignee of record, it is requested the beneficiary of any benefits payable upon death of the insured be distributed as follows:

PRIMARY BENEFICIARY(IES)

Name	Relationship	Address	DOB *(MM/ DD/YYYY)*	SSN	Percentage
			___/___/___		
			___/___/___		
			___/___/___		
			___/___/___		
				Total[1]	

CONTINGENT BENEFICIARY(IES) *if all Primary Beneficiary(ies) predecease you*

Name	Relationship	Address	DOB *(MM/ DD/YYYY)*	SSN	Percentage
			___/___/___		
			___/___/___		
			___/___/___		
			___/___/___		
				Total	

It is understood and agreed upon receipt of this completed, signed, dated designation by IMG, such designation will be effective and relate back to the date it is signed but without prejudice to IMG on account of any payment made prior to receipt and acknowledgement of the validity of the designation by IMG. IMG shall not be obligated to honor this designation until it has been received, acknowledged, and determined by IMG to comply with applicable laws. This designation supersedes and cancels all prior designations by the Insured for any coverage administered by IMG.

The undersigned represents and warrants he/she has not been declared incompetent and no court order or law prevents naming the above beneficiary(ies). It is agreed IMG assumes no responsibility for the validity or effect of any attempted designation or transfer of rights under the insurance contract.

The undersigned also represents and warrants any information and documents provided by the undersigned prior to and after the effective date of coverage and facts and other matters presented in this form are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees that a) any coverage or benefits are contingent upon statements as being complete and correct and b) benefits under any insurance contract will be paid only if the insurer or iTravelInsured decides in its discretion the claimant is entitled to them.

Insured's Signature: X ______________________	Witness Signature: X ______________________
Printed Name:	Printed Name:
Date: ___/___/___ *(MM/ DD/YYYY)*	Date: ___/___/___ *(MM/ DD/YYYY)*

Lack of Notice of Community Property Interest: If IMG has not previously received written notice of a community property interest and if the below consent is not signed by the person having that interest, IMG shall be entitled to rely in good faith no such interest exists. IMG assumes no responsibility to inquire or validate any such interest, and in consideration of submitting this designation, the Insured for himself/herself, his/her estate, heirs, successors, and assigns, agrees to indemnify and hold the insurer and IMG harmless from any consequences of honoring this designation.

Spouse's Signature and Consent *(if applicable)*[2]: X ______________________	Date: ___/___/___ *(MM/ DD/YYYY)*

[1] Total percentage must equal 100% otherwise benefits will be paid on a pro-rata basis according to the percentages shown. If no percentage is identified, benefits will be paid equally.
[2] Spouse's signature needed only if the Insured or Beneficiary resides in a community property state (ie AZ, CA, ID, LA, NM, NV, TX, WA, & WI).