Alternate Payee Form

Please print legibly and complete ALL SECTIONS *(front and back)* of this form. Mail, fax, or email completed form to:
Address: International Medical Group, Inc. Claims, P.O. Box 240429, Apple Valley, MN 55124 USA,
Call: +1.800.628.4664 or outside U.S. +1.317.655.4500; **Fax:** +1.317.655.4505
Email: itravelclaims@itravelinsured.com

The Insured Person may complete the information below and submit a request payment of amounts owed under the insurance contract to be sent to an alternate payee. This form is only a request and International Medical Group, Inc. ("IMG") may grant the request in its sole discretion. Thus, the Insured Person may submit this form as a request to IMG that any amounts owed to the Insured Person under the Insured Person's Insurance Contract (comprised by the application, policy, declaration, and any riders) be sent to an alternate payee, but if, and only if the alternate payee has already paid for medical expenses covered by the Insurance Contract and the alternate payee is not a medical care provider or an agent, affiliate or representative of any medical provider that provided medical care related to the Insured Person in any way.

INSURED INFORMATION

Name of Insured:		Date of Birth: ___/___/___ *(MM/DD/YYYY)*	Insured ID Number:
Mailing Address:			
City:	State/Province:	Postal Code:	Country:
Telephone Number:		Email:	
Insurance Contract Number:			

ALTERNATE PAYEE #1 INFORMATION

Name:		Amount or Percentage:	
Street Address:			
Telephone Number:		Email:	
City:	State/Province:	Postal Code:	Country:

ALTERNATE PAYEE #2 *(if applicable)*

Name:		Amount or Percentage:	
Street Address:			
Telephone Number:		Email:	
City:	State/Province:	Postal Code:	Country:

ALTERNATE PAYEE #3 *(if applicable)*

Name:		Amount or Percentage:	
Street Address:			
Telephone Number:		Email:	
City:	State/Province:	Postal Code:	Country:

AUTHORIZATION:

By signing below, I, the Insured Person, agree and acknowledge that:

(1) Any payments made to an alternate payee for benefits, reimbursements or amounts owed under the Insurance Contract shall discharge IMG's duties under the Insurance Contract as if those payments had been made directly to me and that any amounts owed under the Insurance Contract shall be paid to the alternate payee

(2) This form shall not be used to assign any benefits owed to me to any medical care provider and that if any of the alternate payees listed above are medical care providers who provided care to me or someone covered under my Insurance Contract, this form is null and void

(3) This form—even if signed and authorized—does not alter, amend, or in any way affect the terms and conditions of the Insurance Contract

(4) If there is any conflict between this form and the Insurance Contract, the Insurance Contract supersedes this form

(5) even if IMG authorizes the transfer of payment to the alternate payee pursuant to this form, such authorization has no effect on the eligibility of any claim or the nature, amount or existence of any benefit

(6) To the extent required by the laws of my state or any applicable jurisdiction, my spouse has authorized me to sign this document and I will not use this document to avoid or violate my spouse's rights to any community or marital property

Authorized Signature of Insured: X _____	Date: ___/___/___ *(MM/ DD/YYYY)*