Alternate Payee Form

iTravelInsured®

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.

Mail, fax, or email complete, signed form to:

iTravelInsured®, Inc.
P.O. Box 88503
Indianapolis, IN 46208-0503
Telephone: 1.866.243.7524 or 1.317.655.9798
Fax: 1.317.655.4505
Email: itravelclaims@itravelinsured.com
www.itravelinsured.com

INSURED INFORMATION			
Name of Insured:		Date of Birth:	Insured ID Number:
Mailing Address:			
City:	State/Province:	Zip:	Country:
Telephone Number/Email:		Insurance Contract Number:	
Limited incidents of ownership in the benefits determined by the Company to be payable under the insurance contract, and certain amounts now due under the above numbered insurance contract which are presently owed to the above Insured are hereby allocated and transferred subject to the further conditions of this form, insurance contract, applicable laws, and to any lien, charge, or indebtedness now or hereafter existing in favor of the Company to:			

ALTERNATE PAYEE #1 INFORMATION			
Name:		Amount or Percentage:	SSN/TIN/EIN:
Street Address:		Telephone Number/Email:	
City:	State/Province:	Zip:	Country:

ALTERNATE PAYEE #2 *(if applicable)*			
Name:		Amount or Percentage:	SSN/TIN/EIN:
Street Address:		Telephone Number/Email:	
City:	State/Province:	Zip:	Country:

ALTERNATE PAYEE #3 *(if applicable)*			
Name:		Amount or Percentage:	SSN/TIN/EIN:
Street Address:		Telephone Number/Email:	
City:	State/Province:	Zip:	Country:

AUTHORIZATION

By signing below, I request for an accommodation from and for Company to pay the alternate payee(s) the above amounts, but only up to the amount of benefits owed under the insurance contract. It is understood and agreed upon receipt of this Alternate Payee form by International Medical Group, Inc. its affiliates, or subsidiaries ("Company") at its principal office, such request will become effective and shall relate back to the date this request is signed, but without prejudice to Company on account of any payment made prior to the receipt of and acknowledgement of the validity of the request by Company. Company shall not be obligated to honor this request unless and until it has been received by Company, acknowledged by the appropriate officer of Company, and determined by Company to comply with applicable law at the time a claim is made. This request supersedes and cancels all prior attempted assignments or requests to pay an alternate payee by the Insured for the insurance contract indicated. The Insured hereby declares that he/she has not been declared incompetent and no court order or laws prevent naming the above Alternate Payee(s). It is agreed that Company assumes no responsibility for the validity or effect of any purported assignment or transfer of rights under the insurance contract. The undersigned represents and warrants to Company any information or documents provided to Company by the undersigned prior to and after the date of application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees any insurance coverage or benefits are contingent upon any statements made to Company as being complete and correct. Benefits under any insurance contract will be paid only if Company decides in its discretion the applicant is entitled to them.

Authorized Signature of Insured:	Date *(Mo., Day, Yr.)*:
Authorized Signature of Insured's Spouse[1] ***(if applicable)***:	Date *(Mo., Day, Yr.)*:

[1] Spouse's signature is needed only if Insured lives in a community property state which currently includes AZ, CA, ID, LA, NM, NV. TX, WA and WI.