Trip Cancellation/Trip Interruption Claim Form

Please print legibly and complete ALL SECTIONS (front and back) of this application. Mail, fax, or email application by secure means only:
Address: IMG iTravelInsured® Claims, P.O. Box 3231, Farmington Hills, MI 48333-3231 USA,
Call: 1.866.243.7524 or 1.317.655.9798; **Fax:** +1.317.927.6882
Email: itravelclaims@itravelinsured.com
www.itravelinsured.com

To report a loss, return the required documentation, along with your original, signed claim form to IMG iTravelInsured® Claims. A delay in the processing of the claim will occur if unacceptable proof of loss or an incomplete claim form is submitted. Proof of claim must be submitted within 90 days of the date of loss. IMG reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.

The following documentation will initially be required to begin processing of your claim.

- ☐ The fully completed claim form, signed, and dated
- ☐ The complete trip itinerary & a copy of itemized invoice showing amount paid for trip
  Examples: E-ticket or paper ticket, hotel charges, service fees, and other accommodation expenses
- ☐ Proof of payment for the trip
  Examples: credit card statement, cancelled check, common carrier, and travel supplier receipts
- ☐ Statement from common carrier and travel supplier indicating if any refund, reimbursement, credit, and/or voucher was issued. If no refund, reimbursement, credit, or voucher was issued, a copy of the cancellation terms and conditions must be provided to verify you are not entitled to reimbursement or credits from any other source

If trip was cancelled or interrupted due to sickness, injury, or death, include the medical documentation including but not limited to:

- ☐ Attending physician's statement *(completed by a physician)*
- ☐ Copy of death certificate and obituary *(if applicable)*
- ☐ Proof of relationship *(if cancellation is due to the illness, injury, or death of a family member)*

If the trip was cancelled or interrupted due to other causes, include the additional documents to show proof of loss due to any of the "Other Covered Reasons" identified in the insurance contract:

- ☐ Notice of jury duty or copy of summons to appear in court as a witness
- ☐ Letter from employer outlining dates of hire and termination, attesting to permanent transfer of employment, revocation of previously approved time off, verification of your direct involvement in the merger, or attesting to place of employment being rendered unsuitable for business due to a natural disaster, fire, or burglary
- ☐ Documentation from travel supplier outlining the reason and time frame for cessation of services due to weather, strike, mechanical breakdown, or natural disaster
- ☐ Copy of military orders and documentation from commanding officer verifying call to emergency duty due to Natural disaster or revocation of previously granted leave due to war
- ☐ A police report documenting the theft of passport or the occurrence of an accident occurring while en route to covered trip, which caused cancellation of the trip
- ☐ Copy of quarantine order from government health authority
- ☐ Letter from transportation authority attesting to hijacking incident
- ☐ Documentation verifying terrorist incident within 30 days of departure date in the city you were scheduled to travel during the trip or proof of mandatory evacuation by local government authority at your trip destination due to natural disaster
- ☐ Fire marshal or insurance company report attesting to the fact the primary residence is uninhabitable
- ☐ Proof of hurricane warning issued by National Hurricane Center at the trip destination within 24 hours of your scheduled trip
- ☐ Documentation verifying bankruptcy of travel supplier let to cessation of travel services

PRIMARY CLAIMANT INFORMATION

Insured's Name *(Last, First, Middle)*:		Policy Number:
Mailing Address:		
Email Address:	Home Telephone Number *(With area code)*:	Work Telephone Number *(With area code)*:

PART 1. GENERAL INFORMATION

1. Full Name of Claimant: *(List all claimants. Attach additional sheets if necessary)*	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Policy Number:	Relationship to Insured:
2. Full Name of Claimant:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Policy Number:	Relationship to Insured:
3. Full Name of Claimant:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Policy Number:	Relationship to Insured:
4. Full Name of Claimant:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Policy Number:	Relationship to Insured:

Name of Travel Supplier *(e.g. cruise line, airline, etc.)*:

Travel Agency's Full Name:	Travel Agent's Name:	Telephone Number *(With area code)*:
Travel Agency's Mailing Address:		Email Address:

Initial Deposit Date Paid for Trip: ___/___/___ *(MM/ DD/YYYY)*	Scheduled Departure Date: ___/___/___ *(MM/ DD/YYYY)*	Schedule Return Date: ___/___/___ *(MM/ DD/YYYY)*	Actual Return Date: ___/___/___ *(MM/ DD/YYYY)*
Departure City:		Destination (City, Country, or State):	

Please check the box for benefits requested: ☐ Trip Cancellation ☐ Trip Interruption

- If the cancellation and/or interruption is due to sickness, injury, or death, please complete the entire claim form.
- If the cancellation and/or interruption is due to a non-medical reason(s), please complete Parts 2 and 4.

PART 2. EXPLANATION OF LOSS

Describe in detail what occurred:

Date trip cancelled/interrupted: ___/___/___ *(MM/ DD/YYYY)*	Total paid for trip prior to cancellation *(do not include travel insurance premium)*:	Total paid per insured prior to cancellation *(US$)*:
Total paid for original airfare, per insured (include only if unused airfare is part of the loss claimed):	Did you receive a refund, reimbursement, voucher, or credit from the travel agent, common carrier, or travel supplier? ☐ Yes ☐ No	If yes, please list amount refunded/credited *(US$)*:

Additional losses claimed due to cancellation/interruption:

Type of Expense incurred (hotel, transportation, new tickets):	Date Incurred:	Amount *(US$)*:
1. _____	___/___/___ *(MM/ DD/YYYY)*	_____
2. _____	___/___/___ *(MM/ DD/YYYY)*	_____
3. _____	___/___/___ *(MM/ DD/YYYY)*	_____
Please use a separate sheet of paper for any additional expenses. Proof of payment is required for all losses claimed. Claims cannot be processed without proof of loss.		
	Total Amount of Cancellation/Interruption Losses:	

PART 3. MEDICAL INFORMATION - Complete for cancellation/interruption due to sickness, injury, or death

Patient's Name:	Relationship to Insured:	Date Symptoms First Noticed: ___/___/___ (MM/DD/YYYY)
Nature of Illness:		Date of First Consultation: ___/___/___ (MM/DD/YYYY)
Describe onset, diagnosis, and treatment:		
For injury, describe injury:		Date of First Consultation: ___/___/___ (MM/DD/YYYY)
How and where did the accident occur:		
If hospitalized, hospital name, website, and address:		Dates of Confinement: ___/___/___ (MM/DD/YYYY) From: To:
Name and address of treating physician:		Telephone Number *(with area code)*: Fax Number *(with area code)*:

PART 4. OTHER COVERAGE

Do you have any other insurance or coverage related to the loss *(e.g. medical, travel, etc.)*?	☐ Yes ☐ No
Do you have any other travel insurance coverage?	☐ Yes ☐ No
Did you report the loss to any other insurance company	☐ Yes ☐ No

If Yes, which company:

Name of Company:	Policy/Certificate Number:	Telephone Number *(With area code)*:	Website:
1. _____ Address: _____ _____	_____	_____	_____
2. _____ Address: _____ _____	_____	_____	_____
3. _____ Address: _____ _____	_____	_____	_____
(Please attach a separate sheet if necessary)			

PART 5. CERTIFICATE OF MEDICAL CONDITION/MEDICAL PROVIDER'S STATEMENT

Patient's Name:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Insured's Name:	Patient's Relationship to Insured:
Policy Number:	Policy Purchase Date: ___/___/___ *(MM/ DD/YYYY)*

ATTENDING PHYSICIAN'S STATEMENT—MUST BE COMPLETED AND SIGNED BY THE PHYSICIAN

1. Diagnosis: Nature of sickness/injury causing cancellation/interruption *(Please be specific)*:

a. Primary diagnosis of ICD-9 code: _____

b. Secondary diagnosis of ICD-9 code: _____

2. When did symptoms of sickness or injury first occur? ___/___/___ *(MM/ DD/YYYY)*

3. When did the patient first consult you for this condition? ___/___/___ *(MM/ DD/YYYY)*

4. If patient was referred from another provider, name of provider, address and telephone number *(With area code)*:

5. Name, address, and telephone number of other medical personnel involved:

6. Was there any medical condition, injury, illness, or sickness that would interfere with the insured's trip? ☐ Yes ☐ No

If yes, please explain and indicate when patient was determined not to be medically fit to travel: _____

7. List all dates of treatment and services for this condition

Date of Services: ___/___/___ *(MM/ DD/YYYY)*	Describe the Condition/Treatment:
(Please attach a separate sheet if necessary)	

8. Has the patient been hospitalized for this condition or related condition(s)? ☐ Yes ☐ No

If yes, date of first admission ___/___/___ *(MM/ DD/YYYY)* Date of discharge: ___/___/___ *(MM/ DD/YYYY)*

9. On what date did this condition first prevent or restrict the patient from traveling? ___/___/___ *(MM/ DD/YYYY)*

10. On what date would the patient not be restricted and medically fit to travel?

11. Did you advise the insured to cancel travel plans prior to departure or return home early a result of the sickness or injury?

☐ Yes ☐ No If yes, on what date? ___/___/___ *(MM/ DD/YYYY)* Please explain:

If No, on what date was the insured prevented from participating in the trip? ___/___/___ *(MM/ DD/YYYY)*

12. If condition was related to pregnancy, date of conception: ___/___/___ *(MM/ DD/YYYY)* Expected Delivery Date: ___/___/___ *(MM/ DD/YYYY)*

13. Was this sickness/injury the sole cause of the patient's medically imposed restrictions? ☐ Yes ☐ No

If no, please explain:

Additional physician comments:

Signature of Physician:	Date Completed: ___/___/___ *(MM/ DD/YYYY)*
Name of Physician:	Telephone Number *(With area code)*:
Address of Physician:	
Taxpayer ID Number:	Fax Number *(With area code)*:

CLAIM FORM FRAUD STATEMENT
FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

AUTHORIZATION

The undersigned authorizes any health plan, healthcare provider, healthcare 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 the insured or on the insured's behalf, has any records or knowledge of the insured's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured, and any non-medical information about the insured, to disclose the insured's entire medical record, file, history, medications, and any other information concerning the insured and to give any and all such information to the insured's agent of record and authorized representatives of the insurer, IMG, and their affiliates, and subsidiaries.

This information will be used to evaluate claims for benefits. Individuals have the right to refuse to sign the authorization without negative consequences to treatment or plan enrollment, except IMG will not be able to administer claims, determine benefit eligibility, or issue payments. The authorization is valid for the term of the insurance contract or plan under which a claim has been submitted. The undersigned understands that the insured has the right to receive a copy of this authorization upon request and revoke the authorization at any time in a written communication to IMG. A copy of this shall be as valid as the original. The undersigned acknowledges and understands there is the potential for the information to be subject to redisclosure by the recipient and to no longer be protected by applicable privacy and confidentiality laws.

The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the 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:

1) Any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct
2) Benefits under any contract will be paid only if IMG decides the applicant is entitled to them

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

ACH Transfer Authorization and Agreement Form

Please print legibly and complete ALL SECTIONS (front and back) of this application. Mail, fax, or email application by secure means only:
Address: IMG iTravelInsured® Claims, P.O. Box 3231, Farmington Hills, MI 48333-3231 USA,
Call: 1.866.243.7524 or 1.317.655.9798; **Fax:** +1.317.927.6882
Email: itravelclaims@itravelinsured.com
www.itravelinsured.com

INSURED (REQUESTOR) INFORMATION

Name of Insured:		Date of Birth: ___/___/___ *(MM/ DD/YYYY)*	Insured ID Number:
Street Address *(No P.O. Box):*			
City:	State/Province:	Postal Code:	Country:
Telephone Number/Email:		Wire sent on behalf of *(if applicable):*	

WIRE TRANSFER CURRENCY SELECTIONS

Check destination: ☐ International (outside U.S.)[1] ☐ Domestic (inside U.S.)	For international wires, funds will be sent in the currency of the destination country, where available. If you wish for the funds to be sent in U.S. dollars *(Funds will be converted by local bank, unless recipient has a U.S. dollar account)*, please indicate by checking this box: ☐
Currency type if international *(name of country and unit):*	

BENEFICIARY ("RECIPIENT") INFORMATION

Name:		Telephone Number/Email:	
Address shown on your bank account (no P.O. Box):			
City:	State/Province:	Postal Code:	Country:
SWIFT Code *(Required for international payments):*		International Bank Account Number (IBAN) *(Required if sending Euros):*	

BENEFICIARY BANK ("RECIPIENT BANK") INFORMATION

Bank Name:			
Branch address linked to your account:			
City:	State/Province:	Postal Code:	Country:
Account Number:	ACH Routing Number:		

INTERMEDIARY BANK INFORMATION *(if applicable)*

Bank Name:			
Branch address linked to your account:			
City:	State/Province:	Postal Code:	Country:
Account Number:	ACH Routing Number:		

SPECIAL INSTRUCTIONS *(i.e. If 100% of the benefits owed should not be transferred to the above Beneficiary bank)*

REQUESTOR AUTHORIZATION: By signing below, I request for an accommodation from and for Company to execute the above funds transfer instruction up to the amount of benefits owed in accordance with under the insurance contract for funds transfers set forth in this agreement. I understand and acknowledge Recipients may receive less due to fees charged by the Recipient's bank and taxes, and any cancellation must occur within 30 minutes of sending the request, unless the funds have already been picked up or deposited.

Authorized Signature and Date: X_____	2nd Authorized Signature and Date: ___/___/___ *(MM/ DD/YYYY)*

Message about electronic transmissions: Electronic transmissions via email or fax are not secure and may be intercepted by unauthorized individuals. Please send your claim form by secure means. If you chose to send by insecure means, such as unsecured email, you agree to accept any and all resulting risk.

[1] If sending funds outside of the United States, there may be additional, special fund transfer requirements for international transfers.

Please do not send the Terms & Conditions. Please keep this page for your files. For questions, errors, or issues regarding the transaction, visit www.imglobal.com or call 1.317.655.4500.

Terms and Conditions for Funds Transfers

By requesting a funds transfer order with International Medical Group, Inc., its affiliates, or its subsidiaries (the "Company"), you agree to the following:

Reliance by Company. Company may rely on the information on the form received by it in making your funds transfer. Any errors in the information, including misidentification of Beneficiary(ies), Recipient(s), incorrect or inconsistent account names and numbers, identifying numbers of the intermediary bank or Beneficiary Bank, and misspellings, are your responsibility. If you identify a Beneficiary or other entity by name and account or any other number, payment may be made on the basis of the number and your payment will be final even if the number you provided does not correspond to your Beneficiary or other entity that you have identified.

Bank Fees. Your financial institution may be authorized to debit your account for any fees, costs, or charges related to your funds transfer order. You may have further authorized your financial institution to charge your account a service fee for each funds transfer order you place in accordance with its fee schedule in effect from time to time

Transfer of Beneficiary Bank. When you place an order with Company for a funds transfer, you must select a financial institution as the Beneficiary Bank for the transfer. For transfers within the United States, the Beneficiary Bank must be a member of the Federal Reserve System or a correspondent bank of such a member, or a Clearing House Interbank Payment System (CHIPS) member. You may request that the funds either be deposited to a particular account at the Beneficiary Bank or that they be held at the Beneficiary Bank for your Beneficiary. The Beneficiary Bank will be responsible for following your instructions and for notifying the Beneficiary that the funds are available. After the funds are transferred to the Beneficiary Bank, they become the property of the Beneficiary Bank. The Beneficiary Bank is responsible to locate, identify, and make payment to your Beneficiary. If your Beneficiary cannot be properly identified, the funds may be returned.

Currency of Transfer. Funds transfers to beneficiaries within the United States are made only in U.S. dollars. For funds transfers to beneficiaries and Beneficiary Banks in other countries, unless you choose to send U.S. dollars, the transfer will be made in the currency of that country. For such funds transfers, the financial institution will convert your U.S. dollar payment to the local currency at that financial institution's exchange rate in effect at that time. The exchange rate usually includes a commission to the financial institution for exchanging the currency. Because of the laws of some countries in which Beneficiary Banks are located, if you request a transfer in U.S. dollars the Company cannot guarantee that your Beneficiary will be able to receive U.S. dollars. If your transfer must be converted to the local currency, the Beneficiary Bank may charge a fee for this exchange. Regardless of the currency transferred, the actual amount that your Beneficiary receives may be reduced by charges imposed by the Beneficiary Bank, including those for exchanging currency.

Means of Transfer. Company uses a variety of banking channels and facilities to make funds transfers, but will ordinarily use electronic means. The Company may choose any conventional means that the Company considers suitable to transfer your funds to your Beneficiary. Because the Company does not maintain banking relations with every bank, the Company sometimes uses one or more intermediary banks to transfer your funds to the Beneficiary Bank. After the Company transmits your order to an intermediary bank, that bank is responsible to complete your order.

Recalls/Amendments. You may recall or amend your funds transfer order only if the Company receives your request prior to our execution of the funds transfer order and at a time that provides Company a reasonable opportunity to act upon that request. If your funds transfer order has been executed by Company, the order can be recalled and amended only if the Beneficiary Bank consents to such a request. Company will not be liable to you for any loss resulting from the failure of the Beneficiary Bank to recall or amend your funds transfer order. If you decide you want to recall your funds transfer order and your order has already been executed by Company, you will first have to check with the Beneficiary Bank to determine whether the Beneficiary Bank can return your funds. If the Beneficiary Bank confirms that the funds are returnable and the funds are returned to Company by the Beneficiary Bank, Company may then send a check for the funds to you. The amount that is returned to you may be less than you originally transferred because of service charges of the Beneficiary Bank or Company. Your check will be in U.S. dollars. If your funds transfer was in a foreign currency, your U.S. dollar check will be at the exchange rate on the date of the check.

Rejection of an Order. The Company reserve the right to reject your funds transfer order. The Company may reject your order if you have insufficient information, the order does not comply with applicable laws, the order is inconsistent with rules and regulations of the financial institutions involved, if your order is incomplete or unclear, or if the Company is unable to fulfill your order for any other reason including but not limited to force majeure events.

Delays, Non-Execution of Funds Transfer Order. While the Company will handle your funds transfer order as expeditiously as possible, you agree that Company will not be responsible for any delay, failure to execute, or misexecution of your order due to circumstances beyond Company's reasonable anticipation or control–including without limitations any inaccuracy, interruption, delay in transmission, or failure in the means of transmission, whether caused by strikes, power failures, equipment malfunctions, or acts or omissions of any intermediary bank or Beneficiary Bank. Company MAKES NO WARRANTIES, EXPRESS OR IMPLIED–INCLUDING THE FAILURE OF ANY INTERMEDIARY BANK OR Beneficiary BANK TO CREDIT YOUR Beneficiary WITH THE AMOUNT OF THE FUNDS TRANSFER AFTER RECEIPT OF SAME WITH RESPECT TO ANY MATTER.

Cut-Off Time For Executing Your Funds Transfer Order. If your funds transfer order is received by Company at or after its established cut-off hour for receipt of funds transfer orders, the earliest your funds transfer order can be executed is the next banking day following receipt of all required information.

Claims. You agree that within one hundred eighty (180) days after you receive notification that your funds transfer order has been executed, you will tell Company of any errors, delays or other problems related to your order. Company will determine whether an error occurred within 90 days after you contact Company and any error will be corrected promptly. Company will tell you the results within 3 business days after completing the investigation. If Company decides there was no error, a written explanation will be sent to you. You may ask to appeal an adverse decision by supplying copies of any documents related to the transaction. If your funds transfer order is delayed or erroneously executed as a result of Company's error, Company's sole obligation to you is to pay via check such amounts as may be required by applicable law. In no event shall Company be responsible for any consequential or incidental damages or expenses in connection with your order. Any claim for interest payable by Company shall not be at any published savings account rate in effect within the state of execution of the funds transfer. In any event, if you fail to notify Company of any claim concerning your funds transfer order within one year from the date that you receive notification that your order has been executed, any claim by you will be barred under applicable law.

Governing Law. The Agreement will be governed by the laws of the state of Indiana which is the location through which you initiated this funds transfer and United States federal law as applicable.

Indemnity. In consideration of the agreement by Company to act upon funds transfer instructions in the manner provided in this Agreement, you agree to indemnify and hold Company harmless from and against any and all claims, suits, judgments, executions, liabilities, losses, damages, costs, and expenses–including reasonable attorney's fees–in connection with or arising out of Company acting upon those funds transfer instructions pursuant to this Agreement. This indemnity will be effective to relieve and indemnify Company against its negligence or misconduct.

[2] IMG affiliates and subsidiaries currently include the following companies: iTravelInsured, AkesoCare Management, IMG Europe, International Medical Administrators, Inc., Global Response Ltd., and The IMG Foundation.