SHIP
SHORESIDE HEALTH INSURANCE PLAN

The Cruise Industry's Vacation Medical Plan

Distributed by:

MHG
INSURANCE BROKERS

Signing off?

Take the Shoreside Health Insurance Plan (SHIP) with you!

SHIP is designed to provide protection against costs arising from an illness or accident occurring while on vacation – both at home or wherever else you wish to go.

Plan Features

- Provides coverage for all nationalities between contracts or while on vacation
- Costs as little as $2.08/day with $100 deductible per policy year
- Valid worldwide in any hospital with any doctor
- Up to $500,000 in medical benefits; accidental death benefit of $25,000
- Coverage for SCUBA and winter sports
- Optional Adventure Sports Rider coverage available
- Option to exclude the US and Canada for reduced premiums
- Simple enrollment with next day coverage available
- Administered by International Medical Group, USA and underwritten by Sirius International Insurance, Sweden

Summary of Coverage

Medical Benefit
Up to $500,000 in medical expenses per policy year

Accidental Death & Dismemberment
Up to $25,000 per policy year

Deductible
$100 per policy year

Eligibility

Available to all crew regardless of your nationality or home country, employed on any non-US flagged vessel, while signed off for vacation or on a break between contracts (excluding sick leave). Maximum age for policy issue is 65.

Coverage Period

60 to 180 vacation days per policy year. Unused days carry forward to next sign off in the same policy year.

Underwriting

Sirius International Company (publ) - one of Europe's leading insurance companies

Apply

Apply online with your credit card at www.mhginsurance.com and receive proof of coverage by return e-mail. To apply by mail, complete the attached application and mail it along with the premium to the address on the reverse side of this brochure.

The Policy will not cover conditions already existing at the time of commencing each leave period.

Please refer to the Certificate Wording for specific terms, conditions and other details regarding the benefits, limitations, eligibility and exclusions mentioned in this brochure. Certificate Wordings are available upon request.

Shoreside Health Insurance Plan - Application

1. Applicant Information - Please print clearly		Agent:
Last Name:	First:	Middle Initial:
Gender: ❒ Female ❒ Male	Country of Citizenship:	Date of Birth (MM/DD/YY):
Employer:	Vessel:	Position:
Crew ID Number:	Phone Number:	
Email:		
Correspondence Address:		
State/Province:	Country:	Postal Code:
Beneficiary:	Relationship:	

2. Plan Selection - Please select your Area of Coverage and Period of Coverage			
Plan Area (check one):	❒ Worldwide *including* US & Canada	❒ Worldwide *excluding* US & Canada	
Coverage Period (check one):	❒ 60	❒ 90	❒ 120

Requested Start Date (MM/DD/YY):_____

If your sign off date changes after coverage has been purchased, please contact MHG so that your Effective Date can be updated.

3. Premium Calculation and Payment Method		
Period of Coverage (Shore break period per policy year)	Plan Option 1 Coverage area - Worldwide	Plan Option 2 Coverage area- Worldwide excluding the U.S. & Canada
60 days	$225	$175
90 days	$265	$205
120 days	$325	$250
❒ Optional Adventure Sports Rider: $60 (Available for both plan options)		
$_____ Premium for Plan Option	+ $_____ Premium for Adventure Sports Rider (Optional)	= $_____ Total Premium Due
❒ Check ❒ Visa	❒ Money Order ❒ American Express	❒ MasterCard ❒ Discover

If paying by credit card, I authorize IMG to bill my credit card account for the total charge as specified in the Total Premium Due. Coverage purchased by credit card is subject to validation and acceptance by credit card company.

Card Number:	Expiration Date (MM/YY):
Name As It Appears on Card:	
Billing Address:	
Daytime Phone Number:	
Signature:	

Shoreside Health Insurance Plan - Application

4. 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, to enroll in the S.H.I.P. program 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 as coverage in the event of a sudden and unexpected illness or injury arising when signed off and eligible for coverage, (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) I certify that I am in good health and that I have not been diagnosed with nor suffer from any medical condition for which I foresee any need for future medical treatment or for which I intend to claim under this coverage, and (v) that this coverage does not provide benefits for any illness or injury arising while signed on, nor for any illness or injury which occurred or existed during the 5 years prior to the start date of this insurance, and (vi) 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 the Certificate of Insurance issued to me (us). I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or employment status of myself, to provide this information to International Medical Group, Inc.

Signature:	Date (MM/DD/YY):

Please mail completed enrollment form and relevant premium to:

MHG Services Inc.
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Tel: +1 954 828 1819 **Fax:** +1 954 760 9033 **Email:** sales@mhginsurance.com

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