International Medical Group, Inc.
International Medical Group, Inc. Claims, P.O. Box 240429, Apple Valley, MN 55124 USA,
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Fax 317-655-4505; Email: insurance@imglobal.com

Assignment of Benefits

The undersigned, _____ (the "Patient"), does hereby transfer, assign and
[Printed Name of Insured Person/Patient]

convey to _____ (the "Provider"), all applicable and eligible benefits regarding
[Printed Name of Overseas Hospital or Provider]
payment or reimbursement of claims under the Patient's insurance coverage as provided by Sirius International Insurance Corporation (publ) (the "Company"), as carrier, and as administered by International Medical Group®, Inc. ("IMG®"), acting as authorized agent and Plan Administrator for and on behalf of the Company, under and subject to the terms and conditions of coverage as set forth in the Patient's insurance Certificate/Group Number _____ (the "Certificate"), as the same may relate to medical services, treatment, care, and/or supplies provided to the Patient by the Provider (collectively, the "Coverage Benefits").

Patient further authorizes direct remittance of payment of all Coverage Benefits to the Provider for all eligible and covered medical services and supplies provided to the Patient during all courses of treatment and care provided by the Provider at its facility or otherwise at its direction. The Patient understands and agrees this Assignment of Benefits will have continuing effect for so long as Patient is being treated or cared for by the Provider, and will constitute a continuing authorization, maintained on file with the Provider, which will authorize and allow for direct payment to the Provider of all applicable and eligible Coverage Benefits for all subsequent and continuing treatment, services, supplies and/or care provided to Patient by the Provider. By executing this Assignment of Benefits, the Patient authorizes the Provider and all other persons and entities who provide medical care, services, treatment and/or supplies to the Patient to furnish to the Company, IMG, and their respective authorized agents, employees, affiliated companies, and representatives (including without limitation IMG's wholly-owned subsidiary, Akeso Care Management℠, Inc. ("ACM℠"), a health utilization management and review company) any and all documents, records and other information regarding medical services, treatment and/or supplies performed or provided by the Provider to the Patient, including full and complete copies of all medical records related thereto. The Patient and the Provider acknowledge that Coverage Benefits for any surgical or medical services, to the extent eligible and covered under the Certificate, shall not exceed the usual, reasonable and customary charges for the geographical location of the Provider. The Patient understands and acknowledges that the Patient is directly and personally financially responsible for all medical charges, costs, expenses, claims, supplies and services which are not expressly covered by this Assignment of Benefits and/or which are not covered, applicable or eligible for payment or reimbursement under the terms and conditions of the Certificate or Master Policy as referenced therein.

Important Notice/Disclaimer: The provision, acceptance, and/or use of this Assignment of Benefits form does not constitute and shall not be deemed or construed to constitute the giving or rendering of any legal advice by the Company, IMG, or ACM to any person or entity. The Insured Person/Patient and the Provider are advised and directed to seek and obtain their own independent legal advice and counsel prior to any use of this form, as this form is provided by the Company solely as a courtesy and accommodation to the Patient in connection with the claims administration process, and shall remain subject to each and all of the terms and conditions of the Patient's insurance Certificate. Use or acceptance of this form by either the Insured Person/Patient and/or the Provider shall constitute an agreement and acknowledgment of the foregoing notices, disclaimers, and terms.

Date: _____

_____ _____
Insured/Patient (Signature) Witness (Signature)

_____ _____
Insured/Patient (Printed Name) Witness (Printed Name)