International Medical Group®, Inc.
P.O. Box 88500, Indianapolis, IN 46208-0500 USA

FURLOUGH PREMIUM REQUEST FORM

Please complete the following information to request continuation of the overseas premium for those who are returning to the United States on furlough. Submit the original to International Medical Group with your monthly invoice.

1. **GROUP NAME**_____
2. **NAME OF INDIVIDUAL** _____
3. **NUMBER OF FULL, CONSECUTIVE MONTHS RESIDING OVERSEAS AND PAYING OVERSEAS PREMIUM** _____

If the answer to number 3 is less than 24 months, the individual is not eligible to continue overseas premium while in the United States on furlough.

If the answer to number 3 is 24 months or greater, please see the furlough schedule below. This schedule determines the number of months an individual is eligible to pay the overseas monthly premium while on furlough in the United States. If an individual remains in the United States longer than the schedule dictates, U.S. monthly premium rates will be applicable for the remainder of the furlough period.

Number of Full Months Overseas	***Number of Months of Furlough Available***
less than 24	0
24-29	6
30-35	7
36-42	9
43 or more	12

_____ is eligible for _____ months of furlough.
(Name of Individual) (See chart above)

Please begin furlough on _____. *Date is the date of arrival in the U.S.

Please end furlough on _____. *Date is the date departing the U.S.

_____ _____
(Signature of Person Completing this Form) (Date Submitted)

This form must be completed for all Single or Family participants returning to the United States on furlough. Participants returning to the United States who do not qualify for furlough premium or who do not have this form completed by the group's United States office are subject to paying the United States premium for any month in which they are in the United States on the first day of the month.

Please make a copy for your records. Updated 4/08