



GlobalSelect[®] International Healthcare Cover Application Form

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Underwritten by Sirius International Insurance Corporation (publ) (the "Insurer") Administered, as agent for and on behalf of the Insurer, by International Medical Group, Inc. ("IMG"). Coordinated, as agent for and on behalf of the Insurer for the purposes of receiving premiums, receiving and holding claims money; and receiving and holding premium refunds, by IMG Europe Ltd.

Please complete this form in block capitals using black ink.
For all sections please ensure you give an answer to every question. An incomplete form will delay the processing of your application.

SECTION 1. Your Personal and Cover Details Please complete for all family members applying for cover.

1.1 Details About You

A. Applicant	Title: Mr / Mrs / Miss / Ms / Dr		First Name(s):					
	Surname (Family Name):							
	Date of Birth:	DD/MM/YY	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height:	<input type="checkbox"/> cm <input type="checkbox"/> in	Weight:	<input type="checkbox"/> Kg <input type="checkbox"/> lb
	Occupation:							
	Nationality on Passport:			Passport Number:				

1.2 Details About Members of Your Family Applying for Cover

B. Spouse	First Name(s):		Surname (Family Name):					
	Title: Mr / Mrs / Miss / Ms / Dr							
	Date of Birth:	DD/MM/YY	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height:	<input type="checkbox"/> cm <input type="checkbox"/> in	Weight:	<input type="checkbox"/> Kg <input type="checkbox"/> lb
	Occupation:							
	Nationality on Passport:			Passport Number:				

C. First Child (Below Age 19)	First Name(s):		Surname (Family Name):					
	Date of Birth:	DD/MM/YY	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height:	<input type="checkbox"/> cm <input type="checkbox"/> in	Weight:	<input type="checkbox"/> Kg <input type="checkbox"/> lb
	Nationality on Passport:							
	Passport Number:							

D. Second Child (Below Age 19)	First Name(s):		Surname (Family Name):					
	Date of Birth:	DD/MM/YY	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height:	<input type="checkbox"/> cm <input type="checkbox"/> in	Weight:	<input type="checkbox"/> Kg <input type="checkbox"/> lb
	Nationality on Passport:							
	Passport Number:							

E. Third Child (Below Age 19)	First Name(s):		Surname (Family Name):					
	Date of Birth:	DD/MM/YY	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height:	<input type="checkbox"/> cm <input type="checkbox"/> in	Weight:	<input type="checkbox"/> Kg <input type="checkbox"/> lb
	Nationality on Passport:							
	Passport Number:							

Tick if you have any further dependents and please provide details on a separate sheet.

1.3 Residential Address

Street Address:
Town/City:
State/County:
Postal Code:
Country:

1.4 Mail Forwarding Address (if different from address in 1.3)

Street Address:
Town/City:
State/County:
Postal Code:
Country:

1.5 Contact Details

Primary Telephone: + Country (Area) Number	Other Telephone: + Country (Area) Number
Fax: + Country (Area) Number	Email:

1.6 Select the Geographic Area of Cover You Would Like (Tick One)

<input type="checkbox"/> Area 1 - Europe
<input type="checkbox"/> Area 2 - Worldwide excluding the USA and Canada
<input type="checkbox"/> Area 3 - Worldwide*

1.7 Select The Currency You Would Like For Your Plan (Tick One)

<input type="checkbox"/> GB Pounds (£)
<input type="checkbox"/> US Dollars (\$)
<input type="checkbox"/> EU Euros (€)

The Plan currency also decides your premium currency.

*Important Note: U.S. Citizens & Persons Applying for Cover in the USA

U.S. Citizens:

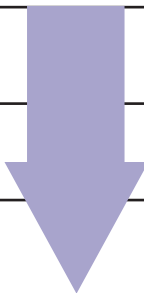
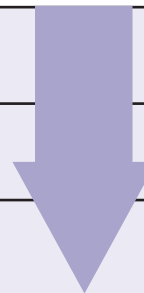
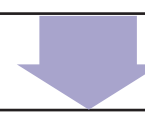
1. Date you did (or will) depart from the USA: ____ / ____ / ____ (DD/MM/YY)
2. Have you arranged to reside outside the USA for at least 180 consecutive days during the next 12 months? Yes No
3. If you or any family member applying for cover are located in the USA on the date of this application, the effective date of this insurance, if issued, will be the later of: a) The effective date requested on the application; or b) The date the insured person departs the USA; or c) The date the application is accepted by IMG and payment of the first full premium is received and the GlobalSelect International Healthcare Cover, including a certificate of insurance, is issued.

Non USA Citizens applying for cover in the USA or located in the USA at time of application:

You must not have been (or arrange to be) located in the USA for any more than 24 consecutive months before or after the Effective Date and you must maintain a permanent residence outside the USA. You must provide a residence address outside the USA. **If you do not**, an Affidavit of Eligibility form must be completed by your insurance advisor/broker.

1.8 Select Which Sub-Plan You Would Like (Tick One Only)

The Voluntary Medical Excesses and premium discounts or increases apply only to the GlobalSelect International Healthcare Cover and not to optional add-on plans or to non-medical sections of cover.

HeadStart	Basic	Standard	Executive
<input type="checkbox"/> £100/\$180/€150 Standard Medical Excess	<input type="checkbox"/> £100/\$180/€150 Standard Medical Excess	<input type="checkbox"/> £50/\$90/€75 Standard Medical Excess	<input type="checkbox"/> £25/\$45/€38 Standard Medical Excess
VOLUNTARY MEDICAL EXCESSES			
			
		<input type="checkbox"/> Nil Excess 10% Premium Increase	<input type="checkbox"/> Nil Excess 10% Premium Increase
			<input type="checkbox"/> £50/\$90/€75 Excess 5% Premium Discount
		<input type="checkbox"/> £100/\$180/€150 Excess 10% Premium Discount	<input type="checkbox"/> £100/\$180/€150 Excess 10% Premium Discount
<input type="checkbox"/> £250/\$450/€375 Excess 20% Premium Discount	<input type="checkbox"/> £250/\$450/€375 Excess 20% Premium Discount	<input type="checkbox"/> £250/\$450/€375 Excess 20% Premium Discount	<input type="checkbox"/> £250/\$450/€375 Excess 20% Premium Discount
<input type="checkbox"/> £500/\$900/€750 Excess 25% Premium Discount	<input type="checkbox"/> £500/\$900/€750 Excess 25% Premium Discount	<input type="checkbox"/> £500/\$900/€750 Excess 25% Premium Discount	<input type="checkbox"/> £500/\$900/€750 Excess 25% Premium Discount
<input type="checkbox"/> £1,000/\$1,800/€1,500 Excess 30% Premium Discount	<input type="checkbox"/> £1,000/\$1,800/€1,500 Excess 30% Premium Discount	<input type="checkbox"/> £1,000/\$1,800/€1,500 Excess 30% Premium Discount	<input type="checkbox"/> £1,000/\$1,800/€1,500 Excess 30% Premium Discount
<input type="checkbox"/> £2,500/\$4,500/€3,750 Excess 35% Premium Discount	<input type="checkbox"/> £2,500/\$4,500/€3,750 Excess 35% Premium Discount	<input type="checkbox"/> £2,500/\$4,500/€3,750 Excess 35% Premium Discount	<input type="checkbox"/> £2,500/\$4,500/€3,750 Excess 35% Premium Discount
<input type="checkbox"/> £5,000/\$9,000/€7,500 Excess 40% Premium Discount	<input type="checkbox"/> £5,000/\$9,000/€7,500 Excess 40% Premium Discount	<input type="checkbox"/> £5,000/\$9,000/€7,500 Excess 40% Premium Discount	<input type="checkbox"/> £5,000/\$9,000/€7,500 Excess 40% Premium Discount
<input type="checkbox"/> £10,000/\$18,000/€15,000 Excess 45% Premium Discount	<input type="checkbox"/> £10,000/\$18,000/€15,000 Excess 45% Premium Discount	<input type="checkbox"/> £10,000/\$18,000/€15,000 Excess 45% Premium Discount	<input type="checkbox"/> £10,000/\$18,000/€15,000 Excess 45% Premium Discount

SECTION 2. Health Declaration

Health Declaration

If YES, show FAMILY MEMBER Using Letters from Section 1.

Please answer all questions for each applicant applying for cover.

1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are you or any other applicant presently hospitalised, or scheduled for or in need of hospitalisation or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

If any applicant answered YES to any of the above four questions, he or she does not qualify for this insurance. Thank you for your interest.

5. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past 5 years? If yes, please complete Section 3.2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. If a non-USA citizen, have you or any other applicant resided continuously in the U.S. for the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

If any applicant answered YES to either of the above two questions, he or she may not qualify for this insurance.

Questions 7 - 26 below must be answered for the applicant and every other member of your family applying for cover. For any question answered "YES," please identify the family member to whom the answer applies (use the letter that corresponds to the family member from Section 1), and provide complete details of the medical condition at issue in the space provided in Section 3.2 of this application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG reserves the right to request additional medical information.

		If YES, show FAMILY MEMBER Using Letters from Section 1.
7. During the last 12 months, have you or any other applicant experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please complete Section 3.2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Have you or any other applicant ever had an application for health, life or disability insurance or reinstatement rejected, cancelled, rated, declined, modified or postponed? If yes, please explain in Section 3.2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you or any other applicant ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:		
9. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, please complete the following: a. Date of most recent BP reading? _____ b. Result: _____ c. Medications taken (Types & Dosage) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Blood, blood vessels, arteries, veins or disorders of the blood, including, but not limited to: anaemia, haemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Diabetes, hyperglycemia or hypoglycemia? If Yes to diabetes, please complete the following: a) Diabetic Type: I ___ or II ___ b) Date diagnosed: _____ c) Controlled by diet only? Yes___ No___ d) Medications (Types and Dosage) _____ e) Date of most recent HbA1c Test? _____ f) Results of HbA1c Test (1 - 10) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

12. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump or growth of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Kidney, urinary tract functions, kidney or bladder stones or infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease, vertebrae, or any other back condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Congenital, genetic or hereditary condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
24. Any other disease, medical problem, illness, injury or condition of any kind not listed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Do you or any other applicant currently use or during the past 5 years have you or any other applicant used tobacco in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26. Have you or any other applicant ever applied for or purchased insurance through IMG? (If yes, please provide certificate number and details.) Certificate Number: _____ Policy Undertaken: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 3. Confidential Medical Information

3.1 Medical Practitioner's Details

The name and address of my usual family doctor is as follows:

Doctor's Name:	Telephone: + Country (Area) Number
Address:	
Country:	Postal/Zip Code:
Date last seen:	Reason:

If the above details are different for any other applicant, please give details on a separate sheet and indicate that you have done so by ticking this box



GLOBAL PERSONAL ACCIDENT PLAN
GLOBAL DAILY INDEMNITYSM - Hospital Income Plan
Optional Additional Covers Application Form

IMG Europe Ltd
 36-38 Church Road, Burgess Hill
 West Sussex, RH15 9AE
 United Kingdom
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Global Personal Accident Plan and Global Daily Indemnity are only available at the time of application for, and with the purchase of, GlobalSelect International Healthcare Cover. To apply, simply complete Section 4 of this Application.

SECTION 4. Application For Global Personal Accident Plan and/or Global Daily Indemnity Insurance

Please indicate the name of each family member applying for Global Personal Accident Plan and/or Global Daily Indemnity.

Name	Personal Accident First unit of cover	Personal Accident Second supplemental unit of cover	Daily Indemnity Cover
A. Applicant	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. First Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	NOT AVAILABLE	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Second Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	NOT AVAILABLE	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Third Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	NOT AVAILABLE	<input type="checkbox"/> Yes <input type="checkbox"/> No

For each individual applying for life insurance, please indicate:			% of Death Benefit
Applicant A	Primary Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
	Contingent Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
Applicant B	Primary Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
	Contingent Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
Applicant C	Primary Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
	Contingent Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
Applicant D	Primary Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
	Contingent Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
Applicant E	Primary Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
	Contingent Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	

Declaration for Global Personal Accident Plan and/or Global Daily Indemnity (If Applicable)

If accepted for the GlobalSelect International Healthcare Cover, I (we) understand that I (we) may qualify for Global Personal Accident Plan and/or Global Daily Indemnity underwritten by Insurer. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorisations, and warranties from the foregoing Application for the GlobalSelect International Healthcare Cover, and understand and agree that the terms, conditions, restrictions and penalties thereof shall likewise apply hereto. If a U.S. citizen, I (we) understand coverage for Global Personal Accident Plan will not be effective prior to the date of my (our) departure from the U.S. If I (we) have also applied for the optional Global Daily Indemnity

plan, I (we) understand that only overnight hospital stays eligible under my (our) GlobalSelect International Healthcare Cover, excluding pregnancies, are covered. I (we) also understand: (i) there is an additional premium for Global Daily Indemnity, (ii) that in the event this Application is not accepted, the premium will be returned to me (us) and neither party will have any obligation, right or liability under the plan, (iii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iv) that the Global Personal Accident Plan and Global Daily Indemnity are issued in England and are governed by the Laws of England.

Signature of Applicant or Guardian:

X

Date :

Signature of Spouse:

X

Date :

SECTION 5. Method and Frequency of Payment

Please choose your method and frequency of payment. The currency you have selected for your plan will also be the currency in which your premium is to be paid.

A. Credit Card					
<input type="checkbox"/>	Frequency of Payment (Please Tick One Only)	<input type="checkbox"/> Annually	<input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly

Note: Choosing the semi-annual payment option results in total payments of 110% of the annual premium, choosing the quarterly payment option results in total payments of 112% of the annual premium, and choosing the monthly payment option results in total payments of 120% of the annual premium.

Your Credit/Debit Card Details

Credit Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Switch <input type="checkbox"/> Solo <input type="checkbox"/> Domestic Maestro			
Full Card Number:			
Start Date:	Expiry Date:	Issue No.: _____ Issue Date: _____ (if applicable)	Security Number: (last 3 digits on signature strip or 4 printed on front of AMEX)
Name as on card:			
Address to which card is registered: (if different from the mailing address given)			
Daytime Telephone: +(Country) (Area) Number			
If paying by credit/debit card, I authorise IMG Europe Ltd. to debit my credit/debit card account above for the total amount due (including any insurance premium taxes if applicable). In the event that I have chosen a semi-annual, quarterly, or monthly payment frequency, I hereby elect to pre-authorise future credit card payment installments for the balance of the annual period of cover (12 months from the Effective Date), and hereby request and authorise IMG Europe Ltd. to charge my credit card periodically as payment installments become due for premiums. This authorisation will remain in effect for 12 months, unless earlier revoked by me in writing and IMG Europe Ltd. actually receives notice of revocation, whereupon continuing cover may be impacted. At all subsequent renewals, I authorise IMG Europe Ltd. to collect the renewal premiums due at that time, on the same payment frequency basis as the previous year until I give written notice that I wish to terminate this agreement. Cover purchased by credit card is subject to validation and acceptance by a credit card company. I understand that I will be given advance notice of the renewal premiums and that they may vary each year.			
Cardholder's Authorisation Signature	X	Date:	DD/MM/YY

If paying by bank transfer or cheque: To avoid delays, we recommend you check your premium calculation and any taxes (if applicable) with us or your agent.

B. Bank Transfer (Annual Premium Payments Only)	
<input type="checkbox"/>	Once your Application has been processed, the necessary bank transfer information will be forwarded to you and your payment is required within 10 days. [Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on any transfer.] Liability for any bank transfer which does not clearly identify the proposer will not be accepted by the Insurer, IMG or IMG Europe Ltd.

C. Bank Cheque / Bankers Draft / Money Order** (Annual Premium Payments Only)	
<input type="checkbox"/>	<p>Please make payable to:</p> <p>IMG Europe Ltd.</p> <p>Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on the reverse of the cheque. ** UK£ Cheque for sterling contract, US\$ cheque for dollar contract or Euro cheque for Euro€ contract</p>

INTERNAL USE ONLY			
_____ X	_____ =	_____ +	_____ + _____
Total Medical Premium	Excess Rate factor	Optional Cover Premium	Insurance Premium Taxes/Levies
= _____			
Total Premium Due			

SECTION 6. Requested Start Date

Date on which you wish your GlobalSelect International Healthcare Cover to commence:

On Acceptance or Other / /

(Must be within 30 days after signature. Cover will in no event be effective until approved.) Please note we cannot commence your plan until we have accepted your Application and received your first or annual premium payment)

SECTION 7. Renewal Contact Information

Please specify the best way to contact you when it comes to renewing your cover:

- Mail (please provide address): _____
- Fax (please provide fax number): + _____ (Country) (Area) Number
- Email (please provide email address) _____

Express Mail Despatch Option

Tick here if you would like your Certificate of Insurance express mailed to you. Please note there will be an additional fee of £15/\$25/€25 to be paid in addition to the premium to have your Certificate of Insurance express mailed to you after approval.

Please select the address where you would like your Certificate express mailed (as indicated in Section 1)

Residence address Mail Forwarding address Other (no P.O. Boxes please) _____

SECTION 8. Insurance Advisor / Broker Use Only

IMG Producer Number #: 243747	Phone: +(Country) (Area) Number 00 1 281 5315368
Company Name: Kent International Group	Fax: +(Country) (Area) Number
Contact Name or Stamp:	E-Mail: kwdc@kentinternationalgroup.com
GA # (if applicable):	

Please mail or fax this application to:

Address change information or additional contact information should also be directed to this contact information.

IMG Europe Ltd
36-38 Church Road, Burgess Hill
West Sussex, RH15 9AE
United Kingdom

Fax: +44 (0) 1444 46 55 50
Call Direct: +44 (0) 1444 46 55 55
Web: www.imgeurope.co.uk