

Enrollment Form/ Evidence of Insurability/Change Form



Participating Organization:		Group I.D. Number:	
CHECK ONE: <input type="checkbox"/> New employee <input type="checkbox"/> Newly acquired dependent <input type="checkbox"/> Late enrollment <input type="checkbox"/> Change of status			
Employee Name: (Last)		(First)	(Middle)
Requested Effective Date:		Occupation:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:		City:	
State:	Zip:	Country:	Telephone: ()
Social Security Number:		Date of Birth:	Passport Number:
Height:	Weight:	Date of Hire:	
Departure Date from U.S.:		Destination:	Length of Stay:

Dependents (Attach a separate sheet, if needed.)

A. I do not have eligible dependents B. I wish to cover my eligible dependents

Name (Last, First, Middle.)	Date of Birth and Date of Marriage for Spouse	HEIGHT	Social Security Number
		WEIGHT	
Spouse			
Dependent Child #1 Sex <input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Child #2 Sex <input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Child #3 Sex <input type="checkbox"/> M <input type="checkbox"/> F			

For dependent children age 19 or older, please indicate name and address of college or university :

The following questions must be answered for each person listed above. For any question where the answer is yes, please provide details of the medical condition on the reverse side of this form or attach a separate sheet if needed. Details must be complete, and must include the following information: name of individual, treatment dates, name, address, and phone number of attending physician, diagnosis, prognosis, and present course of treatment.

1. Are you currently pregnant, hospitalized or disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you <u>ever</u> been diagnosed, treated or tested for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), lymphadenopathy Syndrome or any Immune System Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you <u>ever</u> been diagnosed, treated or tested for Cancer, Diabetes, High Blood Pressure or any Cardiac, Cardiovascular or Heart Condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. During the last 24 months, have you been diagnosed, treated (including medications or consultations) or tested for any medical or mental or nervous condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. During the last 24 months, have you been advised or recommended to have testing, treatment or surgery or do you anticipate testing, treatment or surgery for any medical or mental or nervous condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you <u>ever</u> been rejected, rated or declined for any other Health, Life or Disability Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you <u>ever</u> had Insurance through IMG at any time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Policy or Certificate number: _____	

Have you ever been treated for or have you been told that you have any illnesses, conditions, medical problems, disorders or problems relating to any of the following:

8. Heart? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Mental or nervous? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Blood vessels? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Neurological? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. High blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Bone/skeletal? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Diabetes? (If yes, please complete Supplemental Diabetes Questionnaire.) <input type="checkbox"/> Yes <input type="checkbox"/> No	19. Miscarriage or other complication of pregnancy or delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Gall bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Liver, stomach or intestines? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Do you use tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Kidney? <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Any other condition not listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Lung? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional Comments

Beneficiary: Name _____
 Relationship to Employee _____

I hereby certify that I have read the above statements and all attachments or they have been read to me and the statements are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained herein will void the insurance and all claims will be forfeited. I understand that no coverage is effective until I am notified in writing by the Company, and the Company has the right to refuse to grant coverage. The undersigned authorizes any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policy holder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial and employment status of the individual, to provide this information to International Medical Group, Inc.

I am in good health and except for the conditions disclosed herein, I have not been diagnosed with nor do I suffer from any medical, mental or nervous condition.

Employee Signature: _____ Date: _____
 Spouse Signature: _____ Date: _____

Benefits Change Information

Effective Date (month/date/year): _____

Change of status (check one): Return to U.S. Date of return: _____
 Return to overseas assignment Date of return: _____

INTERNATIONAL MEDICAL GROUP, INC.
 407 N FULTON STREET
 INDIANAPOLIS, IN 46202
 TEL 317-655-4500
 800-628-4664
 FAX 655-4505