

Enrollment Form/Change Form MP INTERNATIONAL sm

INSTRUCTIONS Late Enrollees or Groups with 15 or fewer Covered Employees must complete entire form Groups with 16 or more Covered Employees, Complete Parts 1 & 3

PART 1
I wish the following coverage: **Single Coverage** Coverage to also include eligible dependents
 This application is for: **Late Enrollment** Addition of Dependent(s) Change of Status
 Beneficiary Change Address Change **Name Change** **Removal of Dependent(s)** **Termination Notice**

Participating Organization: _____ Group I.D. Number _____

Employee Name: (Last) _____ (First) _____ (Middle) _____

Occupation: _____ Male Female Height _____ Weight _____

Street Address: _____ City: _____

State: _____ Zip: _____ Country: _____ Telephone: () _____

Social Security Number: _____ Date of Birth: _____ Passport Number: _____

Requested Effective Date: _____ Date Employed Full-Time: _____ Hours Worked Per Week: _____

Departure Date from U.S. _____ Destination: _____ Length of Stay: _____

DEPENDENT INFORMATION (Attach a separate sheet, if needed.)

Name (Last, Middle, First)	Date of Birth and Date of Marriage for Spouse	Height and Weight	Social Security Number
Spouse <input type="checkbox"/> male <input type="checkbox"/> female			
1st Child <input type="checkbox"/> male <input type="checkbox"/> female			
2nd Child <input type="checkbox"/> male <input type="checkbox"/> female			
3rd Child <input type="checkbox"/> male <input type="checkbox"/> female			

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

I refuse coverage for: Myself Spouse Children

Reason: _____

I have been given the opportunity to participate in the group insurance plan offered through my employer and I have refused to participate in the coverage as indicated above. I understand that if coverage is desired at a later date, I may be required to furnish, at my own expense, satisfactory evidence of insurability before coverage becomes effective.

ONLY SIGN HERE IF REFUSING COVERAGE:

Date: _____ Signature: _____

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: 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? Yes No

2. Have you ever been diagnosed, treated or tested for Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC), Lymphadenopathy Syndrome or any Immune System Disorder? Yes No

3. Have you ever been diagnosed, treated or tested for Cancer, Diabetes, High Blood Pressure or any Cardiac, Cardiovascular, Heart or Circulatory Condition? Yes 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? Yes 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? Yes No

6. Have you ever been rejected, rated or declined for any other Health, Life or Disability Insurance? Yes No

7. Have you ever had Insurance through IMG or WASA at any time? Yes No
 If yes, Policy or Certificate number: _____

COMPANY USE ONLY
 WAIVE PRE-EXISTING _____ APPLY PRE-EXISTING UNTIL _____ PRE-EXISTING APPLIES

PART 2

Have you ever been treated for or been told that you have any illnesses, conditions, medical problems, disorders or problems relating to any of the following?: (Please explain all "yes" responses)

- | | | | |
|---|--|--|--|
| 8. Hardening of the Arteries or Blood Vessels | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Mental, Nervous or Neurological | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Alcoholism or Drug Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Reproductive Organs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Liver, Stomach, Intestines or Thyroid | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Bone Skeletal | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Kidney/Sugar, Protein or Blood in Urine | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Miscarriage or other complication of Pregnancy or Delivery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Asthma or Other Disease of Respiratory System | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Gall Bladder or Colon | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | 18. Do you use tobacco in any form? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | 19. Any condition not listed above? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Additional Comments:

PART 3

****MUST BE COMPLETED****

Has any person listed on the prior page, including dependents, been insured or covered for medical expenses under any policy or plan during the last 12 months, whether individual or group? Yes No

If your response to the above question is Yes, the following is required:

1. Name of person(s)
2. A copy of all applicable Certificates of Creditable Coverage

NOTE: Certificates of Creditable Coverage can be obtained from your prior insurer or employer. Failure to submit Certificates of Creditable Coverage may delay your requested effective date. Any claims submitted without Certificates of Creditable Coverage will be processed with any pre-existing condition exclusion as defined by the Group Medical Insurance Master Policy.

BENEFICIARY INFORMATION:

Primary Beneficiary Name: _____	Relationship to Employee: _____	Percent of Death Benefit: _____
Contingent Beneficiary Name: _____	Relationship to Employee: _____	Percent of Death Benefit: _____
Contingent Beneficiary Name: _____	Relationship to Employee: _____	Percent of Death Benefit: _____

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: _____