GEO℠ Group

Enrollment/Change Form *(Organizations with 2 to 10 employees)*

All employees must complete all parts of this form

Insurance Company ("Company") GEO group insurance is underwritten and offered by SiriusPoint International Insurance Corporation, and will be deemed issued and made in Hamilton, Bermuda, governed by Bermuda law, with sole and exclusive jurisdiction and venue for any legal proceeding relating to this insurance in Hamilton, Bermuda.

PART 1.

This form is for:	☐ Employee Only Coverage ☐ Late Enrollment ☐ Beneficiary Change	☐ Name Change ☐ Coverage for Dependents ☐ Address Change	☐ Waiver of Coverage ☐ New Employee ☐ Termination (Initials: _____)	☐ Change of Status ☐ Removal of Dependent(s)

Participating Organization:		Group I.D. Number:	
(A) Full Legal Name: *(Last, First, Middle)*			Citizenship:
Are you a U.S. citizen or resident required to file a U.S. tax return? ☐ Yes ☐ No			
☐ Male ☐ Female	Occupation:	Annual Salary *(Required if applying for a life amount based on 1x, 2x, or 3x salary)*:	Requested Effective Date: ___/___/___ *(MM/DD/YYYY)*
Mailing Address:		City:	State/Country:
Postal/Zip Code:	Telephone:	Country of Residence:	
At the time of this application, are any Applicants currently located in the state of New York? *(If yes, then the purchase of this plan is prohibited)* ☐ Yes ☐ No			
Employee ID Number:	Date of Birth: ___/___/___ *(MM/DD/YYYY)*	Height:	Weight:
Date Employed Full-Time: ___/___/___ *(MM/DD/YYYY)*	Hours Worked per Week:	Departure Date from Country of Residence: ___/___/___ *(MM/DD/YYYY)*	Country of Assignment:
Length of Stay if applicable:	Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? ☐ Yes ☐ No		
Medicare Claim Number if enrolled in Medicare:		SSN/TIN:	Government Issued ID Number:
Communication should be sent via email to:			

☐ I agree to the processing of my personal information to provide the services I have purchased, including to administer claims, and to receive member communications, in accordance with IMG's Privacy Policy.

☐ I agree to receive relevant information and other communications from IMG about Insurance coverages and service options. I understand that I can withdraw my consent at any time.

PART 2. WAIVER OF COVERAGE

I waive coverage for: ☐ Myself and Family Members ☐ Spouse ☐ Children	Reason:
Initials:	Date: ___/___/___ *(MM/DD/YYYY)*

Note: *If you wish to apply for coverage for a person who is not waiving coverage, you must complete the rest of the enrollment form. Do not complete the rest of this form for anyone not applying for coverage.*

PART 3. DEPENDENTS *(attach an additional form for more dependents)* ☐ I am enrolling dependents ☐ I am removing dependents

Name *(Last, First, Middle)*	1) **Date of Birth** *(MM/DD/YYYY)* 2) **Date of marriage to spouse or domestic partnership:** *(MM/DD/YYYY)*	(H) **Height** (ft) (W) **Weight**	(MCN) **Medicare Claim Number if enrolled and** (SSN) **Social Security Number**	**Passport Number**
(B) **Spouse**:	1) ___/___/___ 2) ___/___/___	H: W:	MCN: SSN:	
(C) **Child** #1: ☐ Male ☐ Female	1) ___/___/___	H: W:	MCN: SSN:	
(D) **Child** #2: ☐ Male ☐ Female	1) ___/___/___	H: W:	MCN: SSN:	
(E) **Child** #3: ☐ Male ☐ Female	1) ___/___/___	H: W:	MCN: SSN:	

PART 4.

The questions below must be accurately answered for all applicants. For any question answered "Yes," identify to whom the answer applies (use the letter that corresponds to the applicant from Parts 1 and 3), and provide complete details of the condition in Part 6, including the contact information for all medical providers, and information related to the treatment. IMG and the Company reserve the right to request additional information following review of the answers.

1. Are you or any other applicant currently disabled, pregnant, or unable to work or perform activities of daily living?	☐ Yes ☐ No
2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?	☐ Yes ☐ 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), Lympadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	☐ Yes ☐ No
4. Have you or any other applicant ever had mental or nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abused or dependency, alcoholism, psychiatric counseling and /or support groups, depression, anxiety, chronic fatigue, or eating disorders?	☐ Yes ☐ No
5. 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)?	☐ Yes ☐ No
6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years?	☐ Yes ☐ No
7. Have you or any other applicant ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy?	☐ Yes ☐ No
8. During the last twelve (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 conditions?	☐ Yes ☐ No
9. Have you ever had insurance through IMG or SiriusPoint International Insurance Corporation (publ.) at any time? If yes, please provide us with the policy or certificate number: _____ Your initials here will authorize IMG to cancel existing coverage under your current IMG insurance contract on the same date that your GEO Group coverage becomes effective and only if the group coverage is approved. **X** _____	☐ Yes ☐ No
10. Have you or any other applicant had COVID-19/SARS-CoV-2? Yes ☐ No ☐ a) Date diagnosed ___/___/___ *(MM/DD/YYYY)* b) Date of last treatment ___/___/___ *(MM/DD/YYYY)* c) Were you hospitalized? Yes ☐ No ☐ d) Were you in intensive care? Yes ☐ No ☐ e) Physician/hospital/clinic/health care provider name(s), address & telephone: _____ f) Condition(s)/diagnosis/prognosis/past and present course of treatment(s) _____	☐ Yes ☐ No

PART 5.

Questions 11-27 below must be accurately answered for all applicants. For any question answered "Yes," identify to whom the answer applies (use the letter that corresponds to the applicant from Parts 1 and 3), and provide complete details of the condition in Part 6, including the contact information for all medical providers, and information related to the treatment.

Have you or any other applicant applying for coverage 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:

11. 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? Date of most recent blood pressure reading: ___/___/___ *(MM/DD/YYYY)* Most recent blood pressure reading: _____ AS/ _____ DS Medications (Types / Dosage): _____	☐ Yes ☐ No
12. Blood, blood vessels, arteries, veins or disorders of the blood, including, but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	☐ Yes ☐ No
13. Diabetes, hyperglycemia or hypoglycemia? If Yes to diabetes, please complete the following: a) Diabetic Type: I ____ or II ____ b) Date diagnosed: ___/___/___ *(MM/DD/YYYY)* c) Controlled by diet only? Yes ☐ No ☐ d) Medications (Types / Dosage) _____ e) Date of most recent HbA 1c Test: ___/___/___ *(MM/DD/YYYY)* f) Results of HbA 1c Test (1-10) _____	☐ Yes ☐ No

14. Asthma or allergies? If yes, please specify which one and complete the following: a) Date diagnosed: ___/___/___ *(MM/DD/YYYY)* b) Has hospitalization or emergency room treatment been required? If yes, describe and list date(s): ___/___/___ *(MM/DD/YYYY)* c) Please list known triggers: _____ d) Medications (Types / Dosage) _____ e) Frequency of attacks: _____	☐ Yes ☐ No
15. Cancer, tumor cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump or growth of any kind?	☐ Yes ☐ No
16. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	☐ Yes ☐ No
17. Kidney, urinary tract functions, kidney or bladder stones or infections?	☐ Yes ☐ No
18. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	☐ Yes ☐ No
19. 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?	☐ Yes ☐ No
20. 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?	☐ Yes ☐ No
21. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice diagnosis or treatment?	☐ Yes ☐ No
22. 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?	☐ Yes ☐ No
23. Digestive system, stomach or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	☐ Yes ☐ No
24. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus?	☐ Yes ☐ No
25. Eyes, ears, nose mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation chronic sinusitis, or TMJ?	☐ Yes ☐ No
26. Any other disease, medical problem, illness, injury or condition of any kind not listed?	☐ Yes ☐ No
27. Do you or any other applicant currently use or during the past 5 years have you used tobacco in any form?	☐ Yes ☐ No

PART 6. ADDITIONAL INFORMATION

Question #	Applicant	Condition(s)/Diagnosis and prognosis, past & present course of treatment	Expenses in the last 5 years	Dates of Treatment *(MM/DD/YYYY)*	Medical Provider Name(s), Address, & Telephone

PART 7. ****MUST BE COMPLETED****

Has any applicant, been insured for medical expenses under any policy or plan during the last 12 months, whether individual or group coverage?	☐ Yes ☐ No

If your response to the above question is yes, the following is required:
1) Name of insured **2)** A copy of any Certificates of Creditable Coverage from prior insurer or plan

Note: *An individual must present satisfactory documentation to show the amount of creditable coverage and to calculate deductibles, coinsurance, limits, waiting periods, and/or exclusions.*

PART 8. LIFE INSURANCE BASED UPON MULTIPLE OF EMPLOYEE'S SALARY (if applicable)

☐ 1x Salary	☐ 2x Salary	☐ 3x Salary	☐ Other Amount:

By requesting life insurance and/or any future claim for life benefits I (we) purposefully initiate and take advantage of the privilege of conducting business with International Medical Insurance Group via Alstead Re, a segregated cell company, through IMG as its managing general underwriter and plan administrator, the life insurance contract represented by its Master Policy and evidenced by that Certificate of insurance will be deemed, issued and made in Hamilton, Bermuda, and sole and exclusive jurisdiction and venue for any legal proceeding relating to the life insurance will be in Hamilton Bermuda, for which the applicant(s) hereby consent(s). I (we) consent and agree that Bermuda law shall govern all rights and claims raised under the life insurance contract.

PART 9. EMPLOYEE BENEFICIARY INFORMATION

Beneficiary Name	Relationship	Birth Year *(MM/DD/YYYY)*	Percent of Benefit
Primary Beneficiary #1:		___/___/___	
Primary Beneficiary #2:		___/___/___	
Contingent Beneficiary #1:		___/___/___	
Contingent Beneficiary #2:		___/___/___	

PART 10. CERTIFICATION AND AGREEMENT

1. The person(s) enrolling in this insurance (individually or collectively, "Applicant") represents that the responses provided in this enrollment form are true, accurate, and complete for all persons listed on this application or previously provided to the Company on the GEO RFP, and that the GEO RFP will supplement, and that it will supplement such responses prior to the requested effective date in the event of any change or addition thereto; and that all persons listed on this application are not currently hospitalized, disabled, or HIV+ as of the requested effective date.
2. This insurance contains a number of exclusions from coverage, including an exclusion for pre-existing conditions, and a complete copy of the insurance contract, including all exclusions, has been made available for review and agreement by the Applicant prior to this insurance becoming effective. The Applicant is currently in good health and has not been diagnosed with, sought consultation or been treated for, and has not experienced manifestation or symptoms of and does not suffer from any pre-existing or other medical condition which the Applicant foresees may require treatment during this insurance or for which the Applicant intends to claim under this insurance. The company relies on the accuracy, truthfulness and completeness of the information provided herein and any misrepresentation or omission contained herein will void the insurance contract and any and all claims and benefits thereunder will be forfeited and waived.
3. The Applicant understands and agrees that, subject to Company's acceptance of this application and payment of the total amount due, coverage will begin at 12:01 a.m. on the approved effective date.
4. The Applicant agrees to receive information and communicate electronically, and prefers to use email rather than regular mail. The Applicant agrees that IMG may provide any communications in electronic format, and IMG is not required to send paper communications, unless and until the Applicant withdraws this consent. The Applicant also agrees to be responsible for providing IMG with true, accurate and complete email address, contact, and other information related to this insurance coverage, and to maintain and promptly update any changes in this information.

FRAUD NOTICE. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AUTHORIZATION FOR RELEASE OF INFORMATION. The Applicant hereby authorizes any health plan, health care provider, health care professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to the Applicant or on the Applicant's behalf, has any records or knowledge of the Applicant's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the Applicant, and any non-medical information, to disclose Applicant's entire medical record, file, history, medications, and any other information concerning the Applicant and to give any and all such information to the Applicant's agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

Employee Signature: X _____	Date: ___/___/___ *(MM/DD/YYYY)*
Spouse Signature: X _____	Date: ___/___/___ *(MM/DD/YYYY)*

BENEFITS CHANGE INFORMATION: EMPLOYER USE ONLY

Effective Date: ___/___/___ *(MM/DD/YYYY)*

Change of Status *(Check one):*	☐ Return to the U.S. Date of Return: ___/___/___ *(MM/DD/YYYY)*	☐ Return to overseas assignment Date of Return: ___/___/___ *(MM/DD/YYYY)*

International Medical Group®

Send by one of the following secure methods:

Secure Message Center: www.imglobal.com/secure-message-center
Mail: International Medical Group,
2960 North Meridian Street, Ste. 300, Indianapolis, IN, 46208
Fax: +1.317.655.4505

For other inquiries, contact IMG by:

Phone: +317.655.4500
Email: insurance@imglobal.com