MP+ International Enrollment/Change Form

INTERNATIONAL MEDICAL GROUP

Organizations with 2 to 10 employees

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)
Participation Organization:		Group I.D. Number:	
Employee Name *(Last, First, Middle)*:			Citizenship:
❑ Male ❑ Female	Occupation:	Annual Salary *(Required if applying for a life amount based on 1x, 2x, or 3x salary)*:	Requested Effective Date *(Day, Mo., Yr.)*:
Mailing Address:		City:	State/Country:
Postal/Zip Code:	Country of residence:	Telephone:	Email Address:
Employer Identification Number:	Date of Birth *(Day, Mo., Yr.)*:	Height:	Weight:
Date Employed Full-Time *(Day, Mo., Yr.)*:	Hours Worked per Week:	Departure Date from Country of Residence *(Day, Mo., Yr.)*:	Country of Destination:
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:		Social Security Number	

WAIVER OF COVERAGE	
I waive coverage for: ❑ Myself and Family Members ❑ Spouse ❑ Children	Reason:
Initials:	Date *(Day, Mo., Yr.)*:
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.*	

DEPENDENTS *(ATTACH AN ADDITIONAL FORM FOR MORE DEPENDENTS)* ❑ I am enrolling dependents ❑ I am removing dependents			
Name *(Last, First, Middle)*	1) Date of Birth *(Day, Mo., Yr.)*	Height (H) Weight (W)	Medicare Claim Number (MCN) if enrolled and Social Security Number (SSN)
B) Spouse:	1) 2) Date of marriage to spouse *(Day, Mo., Yr.)*	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:
For children age 19 or older, indicate name and website of college or university ***and the number of enrolled hours:***			

PART 2

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 Part 1), and provide complete details of the condition in Part 4, 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 Sirius International 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 MP+ coverage becomes effective and only if the group coverage is approved **X**_____	❑ Yes ❑ No
10. During the last twelve (12) months, have you or any other applicant been covered under any plan or contract providing health or medical benefits? If yes, please state the name and location of the insurance company, plan administrator, the policy/plan number, and the dates of coverage.	❑ Yes ❑ No

PART 3

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 Part 1), and provide complete details of the condition in Part 4, 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:_____ 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: _____ c) Controlled by diet only? Yes _____ No _____ d) Medications (Types / Dosage) _____ e) Date of most recent HbA 1c Test _____ 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: _____ b) Has hospitalization or emergency room treatment been required? If yes, describe and list date(s):_____ 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 4 ADDITIONAL INFORMATION

Question #	Applicant	Condition(s)/Diagnosis and prognosis, past & present course of treatment	Expenses in last 5 years	Dates of Treatment *(Day, Mo., Yr.)*	Medical Provider Name(s), Address, & Telephone

PART 5 ****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 6 LIFE INSURANCE Based upon multiple of employer reported salary			
❑ 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 IMIC in Bermuda, 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.

EMPLOYEE BENEFICIARY INFORMATION

Beneficiary Name	Relationship	Birth Year	Percent of Benefit
Primary Beneficiary #1:			
Primary Beneficiary #2:			
Contingent Beneficiary #1:			
Contingent Beneficiary #2:			

PART 7

SUBSCRIPTION I (we) hereby apply for MP International insurance coverage as underwritten and offered by the Company reflected in the Participating Organization's insurance application on the date of receipt hereof and as administered by the Company's authorized representative and plan administrator, International Medical Group, Inc. (IMG). I (we) understand and agree: (i) the insurance applied for is not general health insurance, but is intended for my (our) use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) I (we) must pay premiums for the entire period of coverage in advance, and no coverage will be effective until the required premium has been paid and this application has been accepted in writing by the Company, (iii) no modification or waiver relating to this application or the coverage applied for will be binding upon the Company or IMG unless approved in writing by an officer of the Company or IMG, and (iv) 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 certificate and any and all claims and benefits thereunder will be forfeited and waived, (v) by submission of this application and/or any future claim for benefits I (we) purposefully initiate and take advantage of the privilege of conducting business with the Company in Bermuda, through IMG as its managing general underwriter and plan administrator, the contract of insurance represented by the Master Policy and evidenced by the 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 this insurance will be in Hamilton, Bermuda, for which applicant(s) hereby consent(s). I (we) consent and agree that Bermuda law shall govern all rights and claims raised under the insurance contract.

ACKNOWLEDGEMENT I (we) understand and agree that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of applicant(s) and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) this insurance does not provide benefits for any illness, injury, sickness, disease, or other physical, medical, mental or nervous disorder, condition or ailment for which 1) medical advice, diagnosis, care or treatment was recommended or received during the period shown in the contract and prior to the insured's initial effective date or 2) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the period shown in the contract and preceding the insured's initial effective date (a "pre-existing condition"), and that all charges and/or claims incurred for pre-existing conditions will be excluded from coverage under this insurance, (iii) the subjects of insurance applied for are not intended or considered by the applicant(s), the Company or IMG to be resident, located, or expressly to be performed in any particular jurisdiction, and (iv) the Company, as carrier and underwriter of the insurance plan, is solely liable for the coverages and benefits to be provided under the insurance contract and IMG has no direct or independent liability under any insurance contract.

AUTHORIZATION FOR RELEASE OF INFORMATION I (we) authorize 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 me or on my behalf, has any records or knowledge of my health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to disclose my entire medical record, file, history, medications, and any other information concerning me and to give any and all such information to my agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

CERTIFICATION I (we) hereby certify, represent and warrant that : (i) I (we) have read the foregoing statements and any marketing materials and sample insurance contract which were made available upon request and prior to the application or that they have been read to me (us), and I (we) understand them, (ii) I am (we are) eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) I am (we are) currently in good health and have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing or other medical condition which I (we) foresee may require treatment during this insurance or for which I (we) intend to claim under this insurance. If signed as the legal representative of the applicant, the signer warrants their authority and capacity to so act and to bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant(s).

CERTIFICATION I (we) hereby certify, represent, and warrant that I (we) have read, or have had read to me (us), all statements on this application. I (we) represent that the responses are true, accurate, and complete and that I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto; and that all travelers listed on this application are not currently hospitalized, disabled, or HIV+ and will be medically able to travel on the requested effective date. I (we) understand and agree 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 day after this completed application is received and approved. I (we) understand that if premium is returned unpaid for any reason, coverage becomes null and void. I acknowledge and understand that if not completely satisfied after receiving the insurance contract, the insured person may request cancellation of the insurance retroactive to the effective date by sending a written request to the Company within the review period outlined in the insurance contract, and thereby receive a refund of premium paid. I wish to receive information and communicate electronically, and prefer to use my email address rather than regular mail. I agree IMG may provide me with any communications in electronic format, and IMG is not required to send paper communications to me, unless and until I withdraw this consent. I also agree it is my responsibility to provide IMG with true, accurate and complete e-mail address, contact, and other information related to my coverage, and to maintain and promptly update any changes in this information. 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.

Employee Signature:	Date *(Day, Mo. Yr.)*:
Spouse Signature:	Date *(Day, Mo. Yr.)*:

BENEFITS CHANGE INFORMATION: EMPLOYER USE ONLY

Effective Date *(Day, Mo. Yr.)*:		
Change of Status *(Check one):*	❑ Return to the U.S. Date of Return *(Day, Mo. Yr.)*:	❑ Return to overseas assignment Date of Return *(Day, Mo. Yr.)*:

International Medical Group®, Inc.
P.O. Box 88500, Indianapolis, IN 46208-0500
Phone: 1.317.655.4500 or 1.800.628.4664 Fax: 1.317.655.4505
insurance@imglobal.com www.imglobal.com