MP+International

Group Enrollment/Change Form

Organizations with 2 to 10 employees

Please complete all applicable parts of the form.

PART 1 MUST BE COMPLETED

This form is for:	☐ Employee Only Coverage ☐ Late Enrollment ☐ Beneficiary Change ☐ Name Change	☐ Life Insurance Enrollment *(If requesting a life insurance amount of $100,000 or more, please fill out the questions in sections 4-6)* ☐ Coverage for Dependents ☐ Address Change ☐ Waiver of Coverage	☐ New Employee ☐ Termination (Initials:) ☐ Change of Status ☐ Removal of Dependent(s)

Participating Organization:		Group ID Number:	
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 not available)* ☐ 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 recieve 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** 2) **Date of marriage to spouse or domestic partnership**	(H) **Height** (W) **Weight**	(MCN) **Medicare Claim Number if enrolled and** (SSN) **Social Security Number**	**Passport Number**
(A) Spouse:	1) *(MM/DD/YYYY)* 2) *(MM/DD/YYYY*	H: W:	MCN: SSN:	
(B) Child #1: ☐ Male ☐ Female	1) *(MM/DD/YYYY*	H: W:	MCN: SSN:	
(C) Child #2: ☐ Male ☐ Female	1) *(MM/DD/YYYY*	H: W:	MCN: SSN:	
(D) Child #3: ☐ Male ☐ Female	1) *(MM/DD/YYYY*	H: W:	MCN: SSN:	

If enrolling a newborn onto the plan, please answer the following questions:

Is the newborn you are currently requesting to enroll the result of in vitro fertilization (IVF) or any other type of a medically assisted conception?

☐ Yes ☐ No

If so, please provide details, the name, and complete address of the physician or facility where treatment was rendered.

Did the mother or the father of the newborn receive any form of infertility treatment or other medical assistance designed to improve the likelihood of conception, including medication? ☐ Yes ☐ No

If so, please provide details of the treatment in addition to the name and complete address of the physician or facility where treatment was rendered.

PART 4 MUST BE COMPLETED

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 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, 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+International 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? 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 MUST BE COMPLETED

Questions 11-27 below must be accurately answered for all applicants enrolling or modifying coverage. For any question answered "Yes," identify to whom the answer applies (use the letter that corresponds to the applicant from Part 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, or 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.

EMPLOYEE BENEFICIARY INFORMATION

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

GLOBAL peace of mind®

Insurance Company ("Company") MP+International insurance is underwritten and offered by:
SiriusPoint International Insurance Corporation (publ.), 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 9 CERTIFICATION AND AGREEMENT

SUBSCRIPTION As a condition-precedent to applying for this insurance, the undersigned, on behalf and with the authority from the Sponsoring Organization and its individual Participants ("Applicant," "You" or "Your"), represents and warrants they are the authorized agent of the Applicant and hereby applies and subscribes, for and on behalf of each individual enrolled, to the Conyers Trust Company (Bermuda) Limited, Richmond House, 12 Par-la-Ville Road Hamilton HM 08, Bermuda, or its successors, for the insurance coverage requested above and as underwritten and offered by SiriusPoint International Insurance Corporation (publ.) on the date of its receipt hereof, and as administered by the Company's authorized representative and Policy Manager, International Medical Group, Inc (IMG).

APPLICATION The Participating Organization, by its authorized representative, hereby applies for MP+International insurance coverage as underwritten and offered by the Company and administered by the Company's authorized representative and plan administrator, International Medical Group, Inc. (IMG). The Applicant understand and agrees that : (i) the Applicant 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, (ii) 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 (iii) 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 and any and all claims and benefits thereunder will be forfeited and waived.

ACKNOWLEDGEMENT The Applicant understands and agrees that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of the applicant(s) and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) this insurance contains a number of exclusions from coverage, including an exclusion for any illness, injury, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment for which: medical advice, diagnosis, care or Treatment was recommended or received at any time during the six (6) months prior to the effective date or a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Insured person's Initial Effective Date, (iii) the subjects of insurance applied for are not intended or considered by the Applicant, 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, (v) the Applicants also agree it is their responsibility to provide IMG with true, accurate and complete email 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.

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

CERTIFICATION The Applicant hereby certifies, represents and warrants that: (i) the Applicant has read the foregoing statements and any marketing materials and a sample insurance contract that were made available upon request and prior to the application or that they have been read to the Applicant, and the Applicant understands them, (ii) the Applicant is eligible to participate in the insurance program applied for, (iii) if signed as the legal representative of the Applicant, the signer warrants their authority of the signer to so at and bind the Applicant, and (iv) 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. The Applicant understand that if premium is returned unpaid for any reason, coverage becomes null and void.

IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA): This insurance is not subject to, and does not provide benefits required by, PPACA. PPACA requires U.S. citizens, U.S. nationals and resident aliens to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so. Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely the applicants' responsibility to determine the insurance requirements applicable to them and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the applicants may incur, for their failure to obtain coverage required by any applicable law including without limitation PPACA.

E-CONSENT The Applicants wish to receive information and communicate electronically, and prefer to use an email address rather than regular mail. The Applicants agree IMG, its affiliates, and subsidiaries may provide each insured person with any communications in electronic format, and paper communications are not required, unless and until the Applicant withdraws this consent. The Applicants unambiguously give consent to the transfer of personal data to entities established in a country outside the EU Member States. This consent is freely given, specific for the administration of coverage and benefits, and an informed indication of the Applicants' wishes. The Applicants acknowledge and understand the transfer is necessary for the performance of a contract, taken in response to their request, and necessary for the conclusion or performance of a contract concluded in their interest

Employee Signature: X	Date: *(MM/DD/YYYY)*
Authorized Representative 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)*

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 46208-0509 USA
Fax: +1.317.655.4505

For other inquiries, contact IMG by:

Phone: +1.317.655.4500
Email: insurance@imglobal.com