GEO PLUS INTERNATIONAL

Enrollment/Change Form

INTERNATIONAL MEDICAL GROUP℠

INSTRUCTIONS: Late enrollees or groups with 50 or fewer covered employees must complete the entire form. Groups with more than 50 covered employees must complete only Parts 1 and 3.

PART 1

I would like the following coverage:	☐ Single Coverage	☐ Coverage to also include eligible dependents	
This application is for:	☐ New employee	☐ Late enrollment	☐ Addition of dependent(s)
	☐ Change of status	☐ Beneficiary change	☐ Removal of dependent(s)
	☐ Address change	☐ Name change	☐ Termination notice

Participating Organization:		Group I.D. Number:	
Employee Name: (Last)	(First)		(Middle)
Requested Effective Date:	Occupation:	Annual Salary:	☐ Male ☐ Female
Street Address:		City:	
State, Zip:	Country, Telephone Number:	E-mail:	
Identification Number:	Date of Birth:	Social Security Number/Passport Number:	
Height:	Weight:	Date Employed Full-Time:	Hours Worked Per Week:
Departure Date from U.S.:	Destination:	Length of Stay:	

☐ **I am enrolling dependents.** **DEPENDENTS (attach a separate sheet, if needed)**

Name (Last, First, Middle)	Date of Birth & Date of Marriage to Spouse	HEIGHT / WEIGHT	Identification Number
Spouse			SS# PP#
Dependent Child #1 Sex: ☐ M ☐ F			SS# PP#
Dependent Child #2 Sex: ☐ M ☐ F			SS# PP#
Dependent Child #3 Sex: ☐ M ☐ F			SS# PP#

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

I refuse coverage for: ☐ Myself ☐ Spouse ☐ Children

Reason:_____

I have been given the opportunity to participate in the group insurance plan offered though 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. **(SIGN HERE ONLY IF REFUSING COVERAGE)**

Signature:_____ Date:_____

Printed Name:_____

The questions below must be answered for the applicant and every family member included on this Application. For any question that has been answered "YES," please identify the family member to whom the answer applies, and provide complete details of the medical condition at issue on a separate sheet of paper, including the name, address and telephone number of all attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG reserves the right to request additional medical information.

1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	☐ Yes ☐ No
2. 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), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	☐ Yes ☐ No
3. During the last 24 months, have you or any family member applying for coverage been diagnosed with any medical condition or received any treatment (including medications or consultations) for any medical, mental, physical or nervous condition?	☐ Yes ☐ No
4. During the last 24 months, have you or any family member applying for coverage been advised or recommended to have testing, treatment or surgery or do you anticipate testing, treatment or surgery for any medical, mental or nervous condition?	☐ Yes ☐ No
5. Have you or any family member applying for coverage ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy? If yes, please explain:	☐ Yes ☐ No
6. Have you or any family member applying for coverage ever applied for or purchased insurance through IMG? If yes, please provide policy number and details:	☐ Yes ☐ No

COMPANY USE ONLY: WAIVE PRE-EXISTING APPLY PRE-EXISTING UNTIL_____ PRE-EXISTING APPLIES

PART 2

Have you or any family member applying for coverage ever suffered from, been treated for, or been told that you (they) have any diseases, conditions, illnesses, medical problems, disorders, sicknesses or other problems arising from, involving, or relating to any of the following? For any question that has been answered "YES," please identify the family member to whom the answer applies, and provide complete details of the medical condition at issue on a separate sheet of paper, including the name, address and telephone number of all attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG reserves the right to request additional medical information

7. Heart, Cardiac, Cardiovascular, or Circulatory Condition?	☐ Yes ☐ No
8. Blood Vessels, Arteries, Blood Pressure, or Anemia? (If yes, provide most recent blood pressure reading)	☐ Yes ☐ No
9. Migraines, Chronic Headaches or Stroke?	☐ Yes ☐ No
10. Diabetes? (If yes, please complete supplemental Diabetes Questionnaire)	☐ Yes ☐ No
11. Cancer, Tumor, Cyst, Polyp, Lump or Growth of any kind?	☐ Yes ☐ No
12. Liver, Stomach, Gall Bladder, Colon or Intestines?	☐ Yes ☐ No
13. Kidney or Prostate? (Including testing or examination of the Prostate Gland)	☐ Yes ☐ No
14. Lung, Respiratory System or Asthma?	☐ Yes ☐ No
15. Mental, Nervous or Neurological? Drug Abuse or Alcoholism?	☐ Yes ☐ No
16. Bone or Skeletal, including any disorder of the Knee, Hip, or Back?	☐ Yes ☐ No
17. Reproductive Systems, including Miscarriage, Complications of Pregnancy or Delivery?	☐ Yes ☐ No
18. Do you or any family member applying for coverage currently use tobacco in any form, or have you or any family member used tobacco during the past 5 years?	☐ Yes ☐ No
19. Any other illness, injury or condition of any kind not stated above?	☐ Yes ☐ No

PART 3 ****MUST BE COMPLETED****

Has any person listed on the prior page, including dependents, 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 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 - FOR EACH INDIVIDUAL APPLYING FOR LIFE INSURANCE, PLEASE INDICATE:

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_____

SUBSCRIPTION I understand and agree: (i) that any misrepresentation or omission contained herein will void the insurance certificate, and any and all claims and benefits thereunder will be forfeited and waived, (ii) that IMG and the Company will rely on the accuracy and completeness of the information provided herein, (iii) that no coverage will be effective until this Application has been duly accepted in writing by the Company, (iv) that no modification or waiver relating to this Application or the coverage applied for will be binding upon the Company unless approved in writing by an officer of the Company, and (v) that the Master Policy is issued in the United States, and is governed by its laws.

CERTIFICATION I hereby certify, represent and warrant: (i) that I have read the above questions or they have been read to me, and I understand them, (ii) that my responses to the questions are true, accurate and complete in all respects, (iii) that I am (we are) currently in good health and, except for the conditions and other information disclosed herein, have not been diagnosed with, treated for, and do not suffer from any pre-existing condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance.

MEDICAL RELEASE I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or financial and employment status, to provide such information to IMG and/or the Company.

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_____