

Enrollment/Change Form MP+International



PART 1

I would like the following coverage:		<input type="checkbox"/> Single Coverage	<input type="checkbox"/> Coverage to also include eligible dependents
This application is for:		<input type="checkbox"/> Late enrollment	<input type="checkbox"/> Addition of dependent(s)
		<input type="checkbox"/> Beneficiary change	<input type="checkbox"/> Address change
		<input type="checkbox"/> Name change	<input type="checkbox"/> Termination notice
		<input type="checkbox"/> Change of status	<input type="checkbox"/> Removal of dependent(s)
Participating Organization:		Group I.D. Number:	
Employee Name: (Last)		(First)	(Middle)
Requested Effective Date:	Occupation:	Annual Salary:	<input type="checkbox"/> Male <input type="checkbox"/> 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:	
What is your filing status with the IRS? <input type="checkbox"/> W-2 <input type="checkbox"/> 1099 <input type="checkbox"/> No Compensation			

DEPENDENTS (attach a separate sheet, if needed)

Name (Last, First, Middle)	Date of Birth & Date of Marriage to Spouse	HEIGHT	Identification Number
		WEIGHT	
Spouse			SS# PP#
Dependent Child #1 Sex: <input type="checkbox"/> M <input type="checkbox"/> F			SS# PP#
Dependent Child #2 Sex: <input type="checkbox"/> M <input type="checkbox"/> F			SS# PP#
Dependent Child #3 Sex: <input type="checkbox"/> M <input type="checkbox"/> 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 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. **(SIGN HERE ONLY IF REFUSING COVERAGE)**

Signature: _____ Date: _____

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 include the following: name of individual; treatment dates; name, address and phone number of the attending physician; diagnosis; prognosis; and present course of treatment.

- Are you currently pregnant, hospitalized or disabled? Yes No
- Have you ever been diagnosed, treated or tested positive for Acquired Immune Deficiency Syndrome (AIDS) AIDS Related Complex (ARC), Lymphadenopathy Syndrome or any immune system disorder? Yes No
- Have you ever been diagnosed, treated or tested for cancer, diabetes*, high blood pressure or any cardiac, cardiovascular, heart or circulatory condition? (*Please complete the Diabetes Questionnaire) Yes No
- During the last 24 months, have you been diagnosed, treated (including medications or consultations) or tested for any medical, mental or nervous condition? Yes No
- 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, mental or nervous condition? Yes No
- Have you ever been rejected, rated or declined for any other Health, Life or Disability insurance? Yes No
- Have you ever had insurance through IMG or Sirius International at any time? Yes No
If yes, please provide us with the policy or certificate number:
Your signature here will authorize IMG to cancel your existing coverage under your current IMG certificate on the same date that your MP+ coverage becomes effective and only if the group coverage is made effective

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 below).

- | | | | |
|-------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 8. Hardening of the arteries or blood vessels | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Reproductive organs, including miscarriage or other complication of pregnancy or delivery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Alcoholism or drug abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Bone or skeletal, including any disorder of the knee, hip or back | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Liver, stomach, intestine, thyroid or gallbladder | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Migraine headaches or stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Kidney/sugar, protein or blood in the urine | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Colon or prostate (including testing or examination of the prostate gland) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Asthma or other disease of the respiratory system | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Do you use tobacco in any form? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Mental, nervous or neurological | <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 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

Primary Beneficiary Name _____	Relationship to Employee _____	Percent of Death Benefit _____
Primary Beneficiary Name _____	Relationship to Employee _____	Percent of Death Benefit _____
Primary 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 activity 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 _____