INTERNATIONAL MEDICAL GROUP
P.O. Box 88500
Indianapolis, IN 46208-0500

GROUP EMPLOYER CLAIMS DISCLOSURE STATEMENT

The Employer must complete and return this form within 15 days prior to the effective date of coverage. This information will be treated as confidential by International Medical Group. No coverage will be effective until final approval is given by International Medical Group. The current inforce coverage should not be canceled prior to receiving written acceptance of coverage by International Medical Group.

The Employer is required to disclose:

1. Claims on any one participant (employee or dependent) during the immediately preceding 12 months which have been incurred, paid, pended or expected to exceed $5,000.
2. Participants (employee or dependent) who are or are expected to be absent from work due to work related or non-work related disability on the effective date of coverage, and
3. Participants (employee or dependent) who are or have been pre-certified or confined to a hospital or medical facility prior to the date of completion of this Statement; and
4. Dependent children over the normal termination age who are covered under the plan under a disabled or handicapped child extension provision; and
5. COBRA participants, if applicable (employees and/or dependents); and
6. Participants with a history or a current diagnosis of any serious disease or disorder.

Name	EE/DEP	DOB	Date Disabled	Diagnosis or Nature of Disability	Expected to Return to Work on	Benefits paid last 12 months

☐ **Additional Sheet(s) Attached** ☐ **No Known Claims**

We hereby represent and warrant that the above list is complete and accurate and that nothing has been intentionally and/or negligently omitted. We further acknowledge and agree that this information may be used by International Medical Group in determining the acceptability of the group's risk and that the information contained in this form may result in a change in the rates quoted on the proposal. We understand that no coverage shall be provided unless specifically agreed to in writing by International Medical Group. We also understand that any misrepresentation or failure to provide sought for information may be used as the basis for rescission of coverage.

Employer Name:_____ Date:_____

Signature of Authorized Employer Representative:_____ Title:_____