CREWSELECT INTERNATIONAL℠
EMPLOYEE ENROLLMENT FORM

- Groups with 2 to 20 employees
- All parts of the form must be completed

PART 1	
I would like coverage for the following: ☐ Single Coverage ☐ Coverage to Also Include Eligible Dependents	
This application is for: ☐ New Employee ☐ Late Enrollment ☐ Addition of Dependent(s)	
Vessel/Company Name:	Group/Vessel ID Number:
Employee Name (Last, First, Middle):	
Position on Vessel:	☐ Male ☐ Female
Address (Residence):	
Postal Code/Country:	Telephone/Email:
Government Issued ID Number:	Issuing Country:
Date of Birth (Day/Month/Year):	Requested Effective Date (Day/Month/Year):
Height: cm ☐ in ☐ Weight: kg ☐ lbs ☐	Date Employed Full-Time (Day/Month/Year):

PART 2

I refuse coverage for: ☐ 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. ONLY SIGN HERE IF REFUSING COVERAGE:

Signature: Date (Day/Month/Year):

DEPENDENT INFORMATION (Attach A Separate Sheet If Necessary)

Name (Last, First, Middle)	Date of Birth and Marriage for Spouse (Day/Mo/Yr)	Height and Weight	Government Issued ID Number
A) Spouse ☐ Male ☐ Female		Height: cm ☐ in ☐ Weight: kg ☐ lbs ☐	
B) 1st Child ☐ Male ☐ Female		Height: cm ☐ in ☐ Weight: kg ☐ lbs ☐	
C) 2nd Child ☐ Male ☐ Female		Height: cm ☐ in ☐ Weight: kg ☐ lbs ☐	
D) 3rd Child ☐ Male ☐ Female		Height: cm ☐ in ☐ Weight: kg ☐ lbs ☐	

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

PART 3

The questions below must be answered for the applicant and every family member included on the Application. For any question answered "Yes," please identify to whom the answer applies (use the letter that corresponds to the family member from Part 2), and provide complete details of the medical condition at issue in the space provided in Part 5 of this Application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG and the Company reserve 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. 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? If Yes, please explain:	☐YES ☐NO
7. Have you ever had insurance through IMG or Sirius International Insurance Corporation at any time?	☐YES ☐NO
8. 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
9. During the last twelve (12) months, have you or any family member applying for coverage 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

PART 4

Questions 10-26 below must be answered for the applicant and every family member included on the Application. For any question answered "Yes," please identify to whom the answer applies (use the letter that corresponds to the family member from Part 2), and provide complete details of the medical condition at issue in the space provided in Part 5 of this Application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG and the Company reserve the right to request additional medical information.

Have you or any family member 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:

10. 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
11. 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
12. 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
13. 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
14. Cancer, tumor cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump or growth of any kind?	☐YES ☐NO
15. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	☐YES ☐NO
16. Kidney, urinary tract functions, kidney or bladder stones or infections?	☐YES ☐NO
17. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	☐YES ☐NO

18. 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
19. 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
20. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice diagnosis or treatment?	☐YES ☐NO
21. 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
22. Digestive system, stomach or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	☐YES ☐NO
23. 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
24. Eyes, ears, nose mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation chronic sinusitis, or TMJ?	☐YES ☐NO
25. Any other disease, medical problem, illness, injury or condition of any kind not listed?	☐YES ☐NO
26. Do you or any family member applying for coverage currently use or during the past 5 years have you used tobacco in any form?	☐YES ☐NO
27. During the last twelve (12) months, have you or any family member applying for coverage been covered under any health or medical insurance plan? If Yes, please state the name and location of the insurance company, the policy/plan number, and the applicable dates of coverage.	☐YES ☐NO

PART 5 ADDITIONAL INFORMATION

Question #	Name	Details/Diagnosis of Illness / Accident	Expenses in last 2 Years	Date last treated (Day/Mo/Yr)	Full name and number of all attending physicians

PART 6 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:

PART 7 ACKNOWLEDGEMENT

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 facility, 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 (Day/Month/Year):
Spouse Signature:	Date (Day/Month/Year):

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