International Marine Medical Insurance (IMMI) Group Enrollment/Change Form

Late enrollees or groups with 20 or less covered employees must complete the entire form
Groups with 20 or more employees must complete the entire form excluding section 3

Insurance Company ("Company") IMMI group insurance is underwritten and offered by:
Sirius International Insurance Corporation, 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 1			
This form is for:	❑ Employee Only Coverage ❑ Late Enrollment ❑ Beneficiary Change ❑ Name Change	❑ Coverage for dependents ❑ Address Change ❑ Waiver of Coverage	❑ New Employee ❑ Termination (Initials:_____) ❑ Change of Status ❑ Removal of Dependent(s)
Participating Organization/ Vessel:		Group/ Vessel I.D. 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		SSN/TIN:	Government Issued ID Number:
❑ Male ❑ Female	Occupation:	Annual Salary *(Required if applying for a life amount based on 1x, 2x, or 3x salary)*:	Requested Effective Date: *(month/day/year)*
Mailing Address:		City:	State/Country:
Postal/Zip Code:	Telephone:	Country of residence:	
Date of Birth: *(month/day/year)*	Height:	Weight:	Hours Worked per Week:
Date Employed Full-Time: *(month/day/year)*	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:		Communication should be sent via email to:	

❑ **I AGREE TO THE PROCESSING OF MY PERSONAL INFORMATION, INCLUDING FOR CUSTOMER SERVICE AND MARKETING COMMUNICATIONS, IN ACCORDANCE WITH IMG'S PRIVACY POLICY (WWW.IMGLOBAL.COM/LEGAL/PRIVACY-POLICY)**

WAIVER OF COVERAGE	
I waive coverage for: ❑ Myself and Family Members ❑ Spouse ❑ Children	Reason:
Initials:	Date: *(month/day/year)*

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.*

DEPENDENTS *(attach an additional form for more dependents)* ❑ I am enrolling dependents ❑ I am removing dependents

Name *(Last, First, Middle)*	1) **Date of Birth** *(month/day/year)* 2) **Date of marriage to spouse or domestic partnership:** *(month/day/year)*	(H) **Height** (W) **Weight**	(MCN) **Medicare Claim Number if enrolled and** (SSN) **Social Security Number**	**Passport Number**
(B) Spouse:	1) 2)	H: W:	MCN: SSN:	
(C) Child #1: ❑ Male ❑ Female	1)	H: W:	MCN: SSN:	
(D) Child #2: ❑ Male ❑ Female	1)	H: W:	MCN: SSN:	
(E) Child #3: ❑ Male ❑ Female	1)	H: W:	MCN: SSN:	

PART 2

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 1), and provide complete details of the condition in Part 3, 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, 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), Lymphadenopathy 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 IMMI Group coverage becomes effective and only if the group coverage is approved. **X**_____	❑ Yes ❑ No

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).

1. Hardening of the arteries or blood vessels	❑ Yes ❑ No
2. Alcoholism or drug abuse	❑ Yes ❑ No
3. Liver, stomach, intestine, thyroid, or gallbladder	❑ Yes ❑ No
4. Kidney/ sugar, protein or blood in urine	❑ Yes ❑ No
5. Asthma or other disease of the respiratory system	❑ Yes ❑ No
6. Mental, nervous or neurological	❑ Yes ❑ No
7. Reproductive organs, including miscarriage or other complication of pregnancy or delivery	❑ Yes ❑ No
8. Bone skeletal, including any disorders of the knee, hip or back	❑ Yes ❑ No
9. Migraine headaches or stroke	❑ Yes ❑ No
10. Colon or prostate (including testing or examination of the prostate gland)	❑ Yes ❑ No
11. Do you use tobacco in any form	❑ Yes ❑ No
12. Any condition not listed above	❑ Yes ❑ No

PART 3 ADDITIONAL INFORMATION

Question #	Applicant	Condition(s)/Diagnosis and prognosis, past & present course of treatment	Expenses in the last 5 years	Dates of Treatment *(month/day/year)*	Medical Provider Name(s), Address, & Telephone

EMPLOYEE BENEFICIARY INFORMATION

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

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 IMIC in Bermuda, 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.

PART 4 CERTIFICATION AND AGREEMENT

1. The person(s) enrolling in this insurance (individually or collectively, "Applicant") represents that the responses provided in this enrollment form are true, accurate, and complete for all persons listed on this application, and that it will supplement such responses prior to the requested effective date in the event of any change or addition thereto; and that all persons listed on this application are not currently hospitalized, disabled, or HIV+ as of the requested effective date.

2. This insurance contains a number of exclusions from coverage, including an exclusion for pre-existing conditions, and a complete copy of the insurance contract, including all exclusions, has been made available for review and agreement by the Applicant prior to this insurance becoming effective. The Applicant is currently in good health and has not been diagnosed with, sought consultation or been treated for, and has not experienced manifestation or symptoms of and does not suffer from any pre-existing or other medical condition which the Applicant foresees may require treatment during this insurance or for which the Applicant intends to claim under this insurance.

3. The Applicant understands and agrees that, 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.

4. The Applicant agrees to receive information and communicate electronically, and prefers to use email rather than regular mail. The Applicant agrees that IMG may provide any communications in electronic format, and IMG is not required to send paper communications, unless and until the Applicant withdraws this consent. The Applicant also agrees to be responsible for providing IMG with true, accurate and complete email address, contact, and other information related to this insurance coverage, and to maintain and promptly update any changes in this information.

FRAUD NOTICE 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 Applicant hereby authorizes 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 the Applicant or on the Applicant's behalf, has any records or knowledge of the Applicant's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the Applicant, and any non-medical information, to disclose Applicant's entire medical record, file, history, medications, and any other information concerning the Applicant and to give any and all such information to the Applicant's agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

Employee Signature:	Date: *(month/day/year)*
Spouse Signature:	Date: *(month/day/year)*

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