Enrollment Form/Evidence of Insurability/Change Form

PART 1

Participating Organization:	Group I.D. Number:	
Check one: ☐ New employee ☐ Newly-acquired dependent ☐ Late enrollment ☐ Change of status		
Employee Name: (Last) (First) (Middle)		
Requested Effective Date:	Occupation:	☐ 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 of hire:
Departure Date from U.S.:	Destination:	Length of Stay:

DEPENDENTS (attach a separate sheet, if needed)

☐ **I do not have eligible dependents** ☐ **I wish to cover my eligible dependents**

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***:			

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.	
1. Are you currently pregnant, hospitalized or disabled?	☐ Yes ☐ No
2. 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
3. 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
4. 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
5. 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
6. Have you ever been rejected, rated or declined for any other Health, Life or Disability insurance?	☐ Yes ☐ No
7. Have you ever had insurance through IMG or Sirius International at any time? If yes, please provide us with the policy or certificate number:	☐ Yes ☐ No

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 ☐ Yes ☐ No
9. Alcoholism or drug abuse ☐ Yes ☐ No
10. Liver, stomach, intestine, thyroid or gallbladder ☐ Yes ☐ No
11. Kidney/sugar, protein or blood in the urine ☐ Yes ☐ No
12. Asthma or other disease of the respiratory system ☐ Yes ☐ No
13. Mental, nervous or neurological ☐ Yes ☐ No
14. Reproductive organs, including miscarriage or other complication of pregnancy or delivery ☐ Yes ☐ No
15. Bone or skeletal, including any disorder of the knee, hip or back ☐ Yes ☐ No
16. Migraine headaches or stroke ☐ Yes ☐ No
17. Colon or prostate (including testing or examination of the prostate gland ☐ Yes ☐ No
18. Do you use tobacco in any form? ☐ Yes ☐ No
19. Any condition not listed above? ☐ Yes ☐ No

ADDITIONAL COMMENTS:

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

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