Enrollment Form/Evidence of Insurability/Change Form



PART 1

Participating Organization:				Group I.D. Number:								
Check one:	ee 🔲 I	Newly-acquired depen	dent									
Employee Name: (Last)	(First) (Middle)											
Requested Effective Date: Occupation:							☐ Male	e				
Street Address: City:												
State, Zip: Country, Teleph			e Number: E-mail:									
Identification Number:		Date of Birth:		Social Security Number/Passport Number:								
Height:	Weight:		Date of hire:									
Departure Date from U.S.:		Destination:		Lengtl			h of Stay:					
DEPENDENTS (attach a separate sheet, if needed) I do not have eligible dependents												
Name (Last, First, Middle)			Date of Birth & Date of HEIGHT Marriage to Spouse 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.												
Are you currently pregnant, hospit		☐ 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?								□ No				
Have you ever been diagnosed, to cardiac, cardiovascular, heart or cardiovascular.				☐ 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?								□ No				
During the last 24 months, have y or do you anticipate testing, treatr	☐ Yes	□ No										
6. Have you ever been rejected, rate	d or declined	for any other Health, Life	or Disabili	ty insurance?			☐ Yes	☐ No				
Have you ever had insurance through IMG or Sirius International at any time? If yes, please provide us with the policy or certificate number:								□ No				

PART 2													
Have you ever been treated for or been told th to any of the following? (Please explain all "ye					disorders or problems rela	ating							
8. Hardening of the arteries or blood vessels		☐ Yes ☐		14. Reproductive organs, including miscar other complication of pregnancy or de		No							
Alcoholism or drug abuse		☐ Yes ☐ No	15. Popo or skoletal, including any disorder	or of the Vos D	No								
10. Liver, stomach, intestine, thyroid or gallbladder	□ Y			 Bone or skeletal, including any disorde knee, hip or back 	er of the	INO							
11. Kidney/sugar, protein or blood in the urine		'es	☐ No	16. Migraine headaches or stroke	☐ Yes ☐	No							
12. Asthma or other disease of the respiratory system		'es	☐ No	17. Colon or prostate (including testing or examination of the prostate gland	☐ Yes ☐	No							
13. Mental, nervous or neurological		'es	☐ No	18. Do you use tobacco in any form?	☐ Yes ☐	No							
				19. Any condition not listed above?	☐ Yes ☐	No							
ADDITIONAL COMMENTS:													
BENEFICIARY INFORMATION													
Primary Relationship Beneficiary Name 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 the best of my knowledge and belief. I understand that understand that no coverage is effective until I am not undersigned authorizes any licensed doctor, practitic insurance agency, insurance company, group policy highest or prognosis of any physical or mental conternational Medical Group, Inc. I am in good health a any medical, mental or nervous condition.	at any rified in oner of older, endition	misreportion mistreport mist	oresentating by the healing a yee or be the finance	on contained herein will void the insurance Company, and the Company has the right arts, hospital, clinic, health-related activity nefit plan administrator having information ial and employment status of the individual	and all claims will be forfeit to refuse to grant coverage. pharmacy, government age as to the care, advice, treatr al, to provide this information	ed. I The ency, ment, on to							
Employee Signature	Date:												
Spouse Signature													
BENEFITS CHANGE INFORMATION													
Effective Date (month/date/year)													
\	rn to U		eas assi	Date of return gnment Date of return									

Updated 12/04

International Medical Group, Inc. P.O. Box 88500 Indianapolis, IN 46208-0500 800.628.4664 or 317.655.4500 Fax: 317.655.4505 Insurance@imglobal.com www.imglobal.com