GlobalSelect® Group

Employee Enrolment/Change Form

(Organizations with 25 or more employees)

Please complete this form and return it to IMG Europe with the completed list of participants (employees and dependents). Read the following pages before completing this Enrolment form. All information supplied is treated with the strictest confidence. You must disclose all material facts. Failure to do so may invalidate your cover. A material fact is one which is likely to influence the assessment and acceptance of this application. If you are in any doubt as to if a fact is material, you must disclose it. As the Applicant you must answer all the questions and sign the declaration on behalf of all persons included in this application. Please keep a record of all information/letters supplied by us that relates to entering into this contract. Please return the completed form to your Employer or IMG without delay. No cover is in place until written acceptance has been issued by IMG.

PART 1

Employer /Participating Organisation:	Group I.D. Number:

This section for completion by Employer

This application is for:

- ☐ Single Coverage
- ☐ New Employee
- ☐ Change of status
- ☐ Address change
- ☐ Coverage to also include eligible dependents
- ☐ Late enrolment
- ☐ Removal of dependent(s)
- ☐ Name change
- ☐ Addition of dependent(s)
- ☐ Termination notice

EMPLOYEE APPLICANT DETAILS

Applicant Title: Mr. / Mrs. / Miss / Ms / Dr. ☐ ☐ ☐ ☐ ☐	Surname (Family Name):	First Name(s):

☐ Male ☐ Female	Height: ○ cm / ○ in	Weight: ○ kg / ○ lb	Date of Birth: ___/___/___ (DD/MM/YYYY)	Nationality on Passport:

Address:			
City:	County/Region/State:	Post code:	Country:

Work Telephone:	Fax:	Personal Telephone:
Work Email:	Date Employed Fulltime: ___/___/___ (DD/MM/YYYY)	Personal Email:

Govt. Identification Number*: (☐ Passport Number / ☐ Social Security Number / ☐ Driver's License)	Hours Worked Per Week:

☐	I agree to the processing of my personal information to provide the services I have purchased, including to administer claims, and to recieve member communications, in accordance with IMG's Privacy Policy.
☐	I agree to receive relevant information and other communications from IMG about Insurance coverages and service options. I understand that I can withdraw my consent at any time.

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

Name: *(Last, First, Middle)*	Date of Birth:	Height:	Weight:	Identification Number:*
Spouse: Sex: ☐ Male ☐ Female	___/___/___ (DD/MM/YYYY)	○ cm / ○ in	○ kg / ○ lb	SS# ☐ / PP# ☐ / DL# ☐
Dependent Child #1: Sex: ☐ Male ☐ Female	___/___/___ (DD/MM/YYYY)	○ cm / ○ in	○ kg / ○ lb	SS# ☐ / PP# ☐ / DL# ☐
Dependent Child #2: Sex: ☐ Male ☐ Female	___/___/___ (DD/MM/YYYY)	○ cm / ○ in	○ kg / ○ lb	SS# ☐ / PP# ☐ / DL# ☐
Dependent Child #3: Sex: ☐ Male ☐ Female	___/___/___ (DD/MM/YYYY)	○ cm / ○ in	○ kg / ○ lb	SS# ☐ / PP# ☐ / DL# ☐
Dependent Child #4: Sex: ☐ Male ☐ Female	___/___/___ (DD/MM/YYYY)	○ cm / ○ in	○ kg / ○ lb	SS# ☐ / PP# ☐ / DL# ☐

*Identification Number Key – Tick Type : SS# (Social Security Number); PP# (Passport Number); DL# (Drivers License Number)

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

PART 2 *MUST BE COMPLETED*

1. Have you or any other applicant had COVID-19/SARS-CoV-2? a.) Date diagnosed: ___/___/___ *(DD/MM/YYYY)* b.) Date of last treatment ___/___/___ *(DD/MM/YYYY)* c.) Were you hospitalized? ☐ Yes ☐ No d.) Were you in intensive care? ☐ Yes ☐ No e.) Physician/hospital/clinic/health care provider(s),address & telephone _____ f.) Condition(s)/diagnosis/prognosis/past and present course of treatment(s): _____	☐ Yes ☐ No
Has any person listed on the prior page, including dependents, been insured for medical expenses under any policy or plan during the last 24 months, whether individual or group coverage? If your response to the above question is "yes", the following is requested:	☐ Yes ☐ No

1. Name of person(s):	2. Name of Previous Insurer:	3. A copy of prior Certificates of Health Insurance:
		☐ Attached
		☐ Attached
		☐ Attached

Note: Your prior Health Insurance Certificate(s) can be obtained from your prior insurer or employer. Any claims submitted without prior Certificates of Heath Insurance will be processed with any relevant pre-existing condition exclusion as defined by the Master Policy wording.

Declaration and Agreement:

Enclosed is payment of 1/12th of the estimated annual premium towards the first month's premium.

The Employer understands:

i. no coverage shall be effective unless and until notified in writing by IMG Europe that the Employer's application and all Enrolment Forms for all prospective members have been accepted by IMG Europe. for and on behalf of the Insurer,

ii. any such acceptance is at the sole discretion of IMG Europe. If the Employer's application is accepted, the enclosed deposit will be applied toward payment of the first monthly premium. If the Employer's application is not accepted, IMG's, IMG Europe's and the Insurer's sole obligation will be to return the deposit premium to the Employer,

iii. In the event premiums are not paid by the due date that cover will be automatically cancelled,

iv. as an employer employing persons in foreign jurisdictions, the Employer may be subject to foreign laws with respect to the provision of medical benefits and/or the insurance of those benefits, and agrees that neither the Insurer, nor IMG, nor IMG Europe. have investigated whether or how the purchase of this insurance complies with the laws of any foreign jurisdiction. The Employer further understands and agrees that Employer is solely responsible for compliance with all applicable foreign laws.

I/We hereby declare for and on behalf of the Employer, to the best of my knowledge that the information provided and/or as attached, is complete, true and accurate and that nothing has been intentionally and/or negligently omitted. I/We understand and agree that this declaration will constitute part of the Employer's application and any misrepresentation, failure to provide sought for information or failure to disclose any material facts may result in the contract being void. (If you are in any doubt whether certain facts are material, these should be disclosed). I/We accept that any personal exclusions/limitations relating to an Insured Person's or potential Insured Person's existing cover may be maintained by IMG, IMG Europe and Insurers and this will be noted on an Endorsement to the Insured's Certificate of Insurance.

I/We further acknowledge and agree that this information may be used by International Medical Group (IMG), IMG Europe and the Insurer in determining the acceptability of the Employer's group's risk and that the information contained in this form may result in a change of rates quoted on the proposal. We understand that no coverage shall be provided unless specifically agreed to in writing by IMG or IMG Europe.

For Data Protection Act purposes I/We consent to IMG, IMG Europe and Insurers processing and holding sensitive data about the company and it's Employees/Dependents who apply to be included in the policy and for insurance administration purposes. The information may only be passed to selected third parties. I/We understand that all personal data supplied must be accurate and I/We have specific consent of those applicants to disclose their personal data. I declare that transfer by the Employer of personal data to IMG, IMG Europe., including information relating to employees insured under the Group Policy will not result in violating the Data Protection Act.

If applying for coverage as a habitual resident outside of the EEA and UK or at any time move to a location outside the EEA or UK, Applicant(s) hereby apply and subscribe for and on behalf of each individual enrolled, to become members and beneficiaries of the Conyers Trust Company (Bermuda) Limited, Richmond House, 12 Par-la-Ville Road Hamilton HM 08, Bermuda, or its successors, for the insurance coverage requested above and as underwritten and offered by SiriusPoint International Insurance Corporation (publ) on the date of its receipt hereof, and as administered by the Company's authorized representative and Policy Manager, International Medical Group, Inc (IMG).

Signature of Authorised Employer Representative ✗ _____	Date: ___/___/___ *(MM/DD/YYYY)*
Printed Name:	Title/ Position:

This form must be signed by the Company Secretary or equivalent officer

Agent Name:	Agent Number:

Send by one of the following secure methods:

Secure Message Center: www.imglobal.com/secure-message-center
Mail: International Medical Group®
Kingsgate, High Street, Redhill, Surrey RH1 1SH, UK
Fax: +44.1737.860.600

For other inquiries, contact IMG at:
Phone: +44.1737.306.710
Email: info@imgeurope.co.uk

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