GlobalSelect® Group

Employer's Application & Claims Disclosure Statement

(Organizations with 2 to 24 employees)

The Employer must complete and return this form within 15 days prior to the effective date of coverage with the completed list of participants (employees and dependents). This information will be treated as confidential by IMG Europe. No coverage will be effective for the Group or any individuals within the Group until approval is given for the Group by IMG Europe and current coverage in force should not be cancelled until receiving written acceptance of coverage by IMG Europe.

PROSPECTIVE CERTIFICATE HOLDER *(The Employer)*

Employer Name:			Contact:
Telephone:	Fax:		Email:
Address:			
City:	County/Region/State:	Post code:	Country:
Proposed Effective Date: ___/___/___ *(MM/DD/YYYY)*	Premium Frequency: ❑ Annual ❑ Semi-annual ❑ Quarterly ❑ Monthly		Currency: ❑ £ ❑ € ❑ $
Total Number of Employees Applying for cover:	Total Number of Employees:	Total Number of Eligible Employees:	

❑	I am an authorized representative of the group members and the group members agree to the processing of their personal information to provide the services they have purchased, including to administer claims, and to receive member communications, in accordance with IMG's Privacy Policy.
❑	I am an authorized representative of the group members and the group members agree to receive relevant information and other communications from IMG about insurance coverages and service options. The group members understand that they can withdraw consent at any time.

BENEFITS APPLIED FOR

The Employer applies to IMG Europe for the following GlobalSelect Group coverages and benefits:

Geographical Area of Cover: *(Tick one)*

AREA 1	AREA 2	AREA 3	AREA 4
❑ Europe	❑ Worldwide excluding the USA, Canada, China, Hong Kong, Macau, Japan, Singapore & Taiwan	❑ Worldwide excluding USA & Canada	❑ Worldwide

GlobalSelect Sub-Plan:

❑ Head Start ❑ Basic ❑ Standard

Medical Excess Level:

_____ Per person, per condition, per period of insurance _____ Per Insured Person, Per Period of Insurance

Underwriting:

❑ Full Medical Underwriting ❑ Continuation of Personal Medical Exclusions (CPME) ❑ Medical History Disregarded (MHD)
❑ Moratorium Name of current insurer: _____

Underwriting Future New Group Joiners

❑ Full Medical Underwriting ❑ Moratorium ❑ Continuation of Personal Medical Exclusions (CPME) ❑ Medical History Disregarded (MHD)

Optional Additional Covers:

Global Personal Accident Plan

❑ Not Applied For ❑ One Unit of Cover ❑ Two Units of Cover ❑ Mixed, refer to Census

Global Daily Indemnity Cover	Dental & Optical Cover	Pregnancy Cover
❑ Not Applied for ❑ Yes	❑ Not Applied for ❑ Yes	❑ Not Applied for ❑ Level 1 ❑ Level 2

CLAIMS DISCLOSURE STATEMENT

The Employer must provide details of all persons, employees and their dependents, to be covered by this plan. If you reasonably believe the answer is yes, please provide details in the space provided and attach any additional pages as necessary. Final rates and cover will be based upon the actual enrolment, including previous providers cover/terms.

1. Participants (employee or dependent) who are or are expected to be absent from work due to work related or non-work-related disability on the effective date of coverage. ❑ Yes ❑ No
2. Participants (employee or dependent) who are or have been pre-authorised or confined to a hospital or medical facility prior to the date of completion of this statement, or who are suffering from a medical condition whereby they are planning or likely to result in a need for an in-patient hospital stay. ❑ Yes ❑ No
3. Participants with a history or a current diagnosis or incurred any claims in the past 12 months for cancer or HIV/AIDS. ❑ Yes ❑ No
4. Participants currently on a waiting list or contemplating any type of transplant. ❑ Yes ❑ No

(Attach additional list if necessary)

Full Name	Date of Diagnosis	Medical Condition including current prognosis	Treatment including dates, days and dosages
	___/___/___		
	___/___/___		
	___/___/___		
	___/___/___		
	___/___/___		
	___/___/___		
	___/___/___		
	___/___/___		
	___/___/___		

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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