GlobalSelect® Group International Healthcare Cover

CPME Enrolment/Change Form

- **Groups with 2-24 employees**
- **All parts of this form must be completed**
- **Employees who are refusing cover must complete and submit a Refusal of Coverage Form**

Please 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 Organization:	Group I.D. Number:

This section for completion by Employer
This application is for:

☐ Single Coverage ☐ Coverage to also include eligible dependents
☐ New Employee ☐ Late Enrolment ☐ Addition of Dependent(s)
☐ Change of Status ☐ Removal of Dependent(s) ☐ Termination Notice
☐ Address Change ☐ Name Change

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: ___/___/___ (MM/DD/YYYY)	Nationality on Passport:

Street Address:	Town/City:

State/County/Region:	Country:	Postal/Zip Code:
Work Telephone: + ( ) ( )	Home Telephone: + ( ) ( )	Fax: + ( ) ( )
Work E-mail:	Home E-mail:	Hours Worked Per Week:

Govt. Identification Number*: (☐ Passport Number / ☐ Social Security Number / ☐ Driver's License)	Date Employed Full-Time: ___/___/___ (MM/DD/YYYY)

☐	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 if more than 4 children) ☐ **I am enrolling dependents** ☐ **I am removing dependents**

Name (Last, First, Middle)	Date of Birth	Height	Weight	Identification Number*
Spouse	___/___/___ (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# (Driver's License Number)

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

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PART 2

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
2. Have you or any family member applying for coverage suffered from any form of heart disease, stroke, cancer, insulin dependent diabetes, HIV/AIDS or mental illness in the last 3 years?	☐ Yes ☐ No
3. Have you or any family member applying for coverage been treated in a hospital in the last 12 months?	☐ Yes ☐ No
4. Are you or any family member applying for coverage pregnant, or have any treatment or surgery planned or pending (excluding regular medication)?	☐ Yes ☐ No

PART 3 ADDITIONAL INFORMATION

Question #	Name	Details/Diagnosis of Illness/Accident	Expenses in the last 5 years	Date last treated	Full name and number of all attending physicians
				___/___/___ *(DD/MM/YYYY)*	
				___/___/___ *(DD/MM/YYYY)*	
				___/___/___ *(DD/MM/YYYY)*	
				___/___/___ *(DD/MM/YYYY)*	
				___/___/___ *(DD/MM/YYYY)*	
				___/___/___ *(DD/MM/YYYY)*	

PART 4 *MUST BE COMPLETED*

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?	☐ Yes ☐ No

If your response to the above question is "yes", the following is requested:

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.

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PART 5 *MUST BE COMPLETED*

AGREEMENT

I (we) understand and hereby agree that:

i. (we) choose to apply to enrol for insurance under GlobalSelect Group International Healthcare Cover (and Global Personal Accident Plan and/or Global Daily Indemnity Hospital Income Plan Cover – if selected by the Employer) and no coverage will be in effect until this Application has been duly accepted and coverage confirmed, in writing by IMG;

ii. Cover will be provided in accordance with the Policy Wording; and I (we) will read it upon receipt and be bound by it unless I (we) cancel the plan within 30 days after receiving the Policy Wording.

iii. This Enrolment will be the basis for and form a part of any insurance issued and IMG can and will rely upon the accuracy and completeness of the information provided herein.

iv. I (we) have read all statements, questions and responses contained in this Enrolment or they have been read to me (us) and I (we) understand them.

v. My (our) responses to the statements and questions contained in this Application are true, accurate complete and correctly recorded in all respects including those not in my own handwriting, and I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto.

vi. Any misstatement, misrepresentation or omission contained in this Application will void the insurance applied for, and any and all claims and benefits under the plan will be forfeited and waived.

vii. I am (We are) currently in good health and, except for conditions and other information disclosed herein, have not been diagnosed with, treated for, and do not suffer from any pre-existing medical conditions which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance.

viii. The subjects, risks and benefits of insurance for which I (we) enrol for cover under the plan are not intended or considered by me (us) to be resident, located or performed in any state of the USA or any particular country. The Master Policy Wording is deemed issued in London, England and is governed by the laws of England and Wales.

ix. The Insurer, IMG, their employees, representatives, agents and any other persons or organisations performing services for them or on their behalf, may use, disclose or transfer to any organisation Worldwide any information, including personal information, about me (us) obtained or collected in connection with this Application, (whether contained in this Application or otherwise) for the purpose of: (1) assessing this Application and providing on-going insurance and customer service; (2) processing and giving effect to credit/debit card payments; (3) providing marketing material in respect of insurance related services of IMG or its associated companies; and (4) processing claims or analysing the insurance.

x. I agree that where medical treatment is received within the provider network by myself or any of my dependent and it is substantiated that the treatment or medical condition is not refundable under the terms of the policy, that I shall be fully responsible for reimbursement to IMG within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical treatment. I further accept that where funds have been outstanding to IMG, for a period in excess of 15 days from notification, my cover will be cancelled void ab initio, without refund of premium.

xi. No modification or waiver relating to this Application or the coverage applied for will be binding upon the Insurer unless approved in writing by an authorised officer of the Insurer, IMG.

xii. if this Application is signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant.

xiii. 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).

AUTHORISATION AND MEDICAL RELEASE

I (we) authorise any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator, employer, social worker or family member having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or financial and employment status, to provide information about me (us), including my (our) entire medical record, to SiriusPoint International Insurance Corporation (publ), International Medical Group, Inc., their employees, representatives, agents and any other persons or organisations performing insurance services for them or on their behalf. By my (our) signature below, I (we) acknowledge that any prior agreement I (we) have made to restrict or limit the disclosure of information about my (our) health does not apply to this authorisation.

This authorisation is valid from the date of my (our) signature shown below. A copy, image or facsimile of this authorisation is as valid as the original.

Employee Signature: X _____	Today's Date: ___/___/___ (MM/DD/YYYY)
Spouse's Signature: X _____	Today's Date: ___/___/___ (MM/DD/YYYY)

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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