

GlobalSelect Group is a product underwritten by Sirius International Corporation (the "Insurer"). Distributed, managed and administered as agent for and on behalf of the Company, by International Medical Group®, Inc. (IMG®)

- **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 in 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 to us relating 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:	
<i>This section for completion by Employer</i>					
<input type="checkbox"/> Single Coverage <input type="checkbox"/> Coverage to also include eligible dependents <input type="checkbox"/> New Employee <input type="checkbox"/> Late Enrolment <input type="checkbox"/> Addition of Dependent(s) This application is for: <input type="checkbox"/> Change of Status <input type="checkbox"/> Removal of Dependent(s) <input type="checkbox"/> Termination Notice I would like the following coverage: <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change					
EMPLOYEE APPLICANT DETAILS					
Applicant: Title: Mr. / Mrs. / Miss / Ms / Dr.		Surname (Family Name):		First Name(s):	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: <input type="checkbox"/> cm / <input type="checkbox"/> in	Weight: <input type="checkbox"/> kg / <input type="checkbox"/> lb	Date of Birth: DD/MM/YY	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*: (<input type="checkbox"/> Passport Number / <input type="checkbox"/> Social Security Number / <input type="checkbox"/> Driver's License)				Date Employed Full-Time:	
<input type="checkbox"/> I AGREE TO THE PROCESSING OF MY PERSONAL INFORMATION, INCLUDING FOR CUSTOMER SERVICE AND MARKETING COMMUNICATIONS, IN ACCORDANCE WITH IMG'S PRIVACY POLICY (WWW.IMGGLOBAL.COM/LEGAL/PRIVACY-POLICY)					
DEPENDENTS (attach an additional form if more than 4 children) <input type="checkbox"/> I am enrolling dependents <input type="checkbox"/> I am removing dependents					
Name (Last, First, Middle)		Date of Birth	Height	Weight	Identification Number*
Spouse		DD/MM/YY	<input type="checkbox"/> cm / <input type="checkbox"/> in	<input type="checkbox"/> kg / <input type="checkbox"/> lb	<input type="checkbox"/> SS# / <input type="checkbox"/> PP# / <input type="checkbox"/> DL#
Dependent Child #1 Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		DD/MM/YY	<input type="checkbox"/> cm / <input type="checkbox"/> in	<input type="checkbox"/> kg / <input type="checkbox"/> lb	<input type="checkbox"/> SS# / <input type="checkbox"/> PP# / <input type="checkbox"/> DL#
Dependent Child #2 Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		DD/MM/YY	<input type="checkbox"/> cm / <input type="checkbox"/> in	<input type="checkbox"/> kg / <input type="checkbox"/> lb	<input type="checkbox"/> SS# / <input type="checkbox"/> PP# / <input type="checkbox"/> DL#
Dependent Child #3 Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		DD/MM/YY	<input type="checkbox"/> cm / <input type="checkbox"/> in	<input type="checkbox"/> kg / <input type="checkbox"/> lb	<input type="checkbox"/> SS# / <input type="checkbox"/> PP# / <input type="checkbox"/> DL#
Dependent Child #4 Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		DD/MM/YY	<input type="checkbox"/> cm / <input type="checkbox"/> in	<input type="checkbox"/> kg / <input type="checkbox"/> lb	<input type="checkbox"/> SS# / <input type="checkbox"/> PP# / <input type="checkbox"/> 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:					

PART 2	
1. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you or any family member applying for coverage been treated in a hospital in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you or any family member applying for coverage pregnant, or have any treatment or surgery planned or pending (excluding regular medication)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Attached <input type="checkbox"/> Attached <input type="checkbox"/> Attached	
Note: Your prior Health Insurance Certificate(s) can be obtained from your prior insurer or employer. Any claims submitted without prior Certificates of Health Insurance will be processed with any relevant pre-existing condition exclusion as defined by the Group Medical Insurance Master Policy wording.	

PART 5 - *Must Be Completed*

AGREEMENT I (we) understand and hereby agree that:

(i) 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.

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 Sirius International Insurance Corporation, 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: <input checked="" type="checkbox"/> _____	Today's Date:
Spouse's Signature: <input checked="" type="checkbox"/> _____	Today's Date:

IMG is authorised and regulated by the Financial Conduct Authority.

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