# GlobalSelect® Group

## Employee Enrolment/Change Form

*(Organizations with 11 to 24 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*<br>**This application is for:** | ☐ Single Coverage<br>☐ New Employee<br>☐ Change of status<br>☐ Address change | ☐ Coverage to also include eligible dependents<br>☐ Late enrolment<br>☐ Removal of dependent(s)<br>☐ Name change | ☐ Addition of dependent(s)<br>☐ Termination notice |

### EMPLOYEE APPLICANT DETAILS

| | | | | |
|---|---|---|---|---|
| Applicant Title: Mr. / Mrs. / Miss / Ms / Dr.<br>☐ ☐ ☐ ☐ ☐ | Surname (Family Name): | | | First Name(s): |
| ☐ Male<br>☐ Female | Height:<br>○ cm / ○ in | Weight:<br>○ kg / ○ lb | Date of Birth:<br>__/__/____ (DD/MM/YYYY) | Nationality on Passport: |
| Address: | | | | |
| City: | County/Region/State: | Post code: | | Country: |
| Telephone: | Fax: | Email: | | |
| Hours Worked Per Week: | Govt. Identification Number*:<br>( ☐ Passport Number / ☐ Social Security Number / ☐ Driver's License) | | Date Employed Full-Time:<br>__/__/____ (DD/MM/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 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:


© 2009-2021 International Medical Group, Inc. All rights reserved.

## PART 2

The questions below must be answered for the applicant and every family member included on the Application. For any question answered "Yes," please identify to whom the answer applies (use the letter that corresponds to the family member from Part 1), and provide complete details of the medical condition at issue in the space provided in Part 4 of this Application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG, IMG Europe Ltd and the Company reserve the right to request additional medical information.

| | |
|---|---|
| 1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities? | ❑ Yes ❑ No |
| 2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery? | ❑ Yes ❑ No |
| 3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) Lympadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder? | ❑ Yes ❑ No |
| 4. Have you or any other applicant ever had mental or nervous system disorders including, but not limited to: psychosis, mental or behavioural disorders, chemical or drug abused or dependency, alcoholism, psychiatric counselling and /or support groups, depression, anxiety, chronic fatigue, or eating disorders? | ❑ Yes ❑ No |
| 5. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)? | ❑ Yes ❑ No |
| 6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please explain | ❑ Yes ❑ No |
| 7. Have you or any family member applying for coverage ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy? If yes, please explain: | ❑ Yes ❑ No |
| 8. During the last twelve (12) months, have you or any family member applying for coverage experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental physical or nervous conditions? | ❑ Yes ❑ No |
| 9. Have you or any other applicant had COVID-19/SARS-CoV-2?<br>a.) Date diagnosed: ___/___/___ *(DD/MM/YYYY)*<br>b.) Date of last treatment ___/___/___ *(DD/MM/YYYY)*<br>c.) Were you hospitalized? ❑ Yes ❑ No<br>d.) Were you in intensive care? ❑ Yes ❑ No<br>e.) Physician/hospital/clinic/health care provider(s),address & telephone _____<br>f.) Condition(s)/diagnosis/prognosis/past and present course of treatment(s): _____ | ❑ Yes ❑ No |

## PART 3

Questions 10-27 below must be answered for the applicant and every family member included on the Application. For any question answered "Yes," please identify to whom the answer applies (use the letter that corresponds to the family member from Part 1), and provide complete details of the medical condition at issue in the space provided in Part 4 of this Application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG, IMG Europe Ltd. and the Company reserve the right to request additional medical information.

Have you or any family member applying for coverage ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:

| | |
|---|---|
| 10. Heart, cardiac, cardiovascular and /or circulatory, including , but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur?<br>Date of most recent blood pressure reading: ___/___/___ *(DD/MM/YYYY)*<br>Most recent blood pressure reading: _____AS/_____DS<br>Medications (Types / Dosage): _____ | ❑ Yes ❑ No |
| 11. Blood, blood vessels, arteries, veins or disorders of the blood, including, but not limited to: anaemia, haemophilia, leukaemia, hepatitis, lymph glands, or high cholesterol? | ❑ Yes ❑ No |
| 12. Diabetes, hyperglycemias or hypoglycaemia? If Yes to diabetes, please complete the following:<br>a.) Diabetic Type: I ☐ or II ☐<br>b.) Date diagnosed: ___/___/___ *(DD/MM/YYYY)*<br>c.) Controlled by diet only? ❑ Yes ❑ No<br>d.) Medications (Types / Dosage): _____<br>e.) Date of most recent HbA 1c Test: ___/___/___ *(DD/MM/YYYY)*<br>f.) Results of HbA 1c Test (1-10): _____ | ❑ Yes ❑ No |
| 13. Asthma or allergies? If yes, please specify which one and complete the following:<br>a.) Date diagnosed: ___/___/___ *(DD/MM/YYYY)*<br>b.) Has hospitalisation or emergency room treatment been required? If yes, describe and list date(s): _____<br>c.) Please list known triggers: _____<br>d.) Medications (Types / Dosage): _____<br>e.) Frequency of attacks: _____ | ❑ Yes ❑ No |


© 2009-2021 International Medical Group, Inc. All rights reserved.

| | |
|---|---|
| 14. Cancer, tumour cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump or growth of any kind? | ❑ Yes ❑ No |
| 15. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity? | ❑ Yes ❑ No |
| 16. Kidney, urinary tract functions, kidney or bladder stones or infections? | ❑ Yes ❑ No |
| 17. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia? | ❑ Yes ❑ No |
| 18. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks? | ❑ Yes ❑ No |
| 19. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease, vertebrae, or any other back condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation? | ❑ Yes ❑ No |
| 20. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice diagnosis or treatment? | ❑ Yes ❑ No |
| 21. Congenital, genetic or hereditary condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect? | ❑ Yes ❑ No |
| 22. Digestive system, stomach or intestines, including, but not limited to: oesophageal regurgitation, gastritis, ulcers, colon, or rectum disorders? | ❑ Yes ❑ No |
| 23. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus? | ❑ Yes ❑ No |
| 24. Eyes, ears, nose mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation chronic sinusitis, or TMJ? | ❑ Yes ❑ No |
| 25. Any other disease, medical problem, illness, injury or condition of any kind not listed? | ❑ Yes ❑ No |
| 26. Do you or any family member applying for coverage currently use or during the past 5 years have you used tobacco in any form? | ❑ Yes ❑ No |
| 27. Have you or any family member applying for coverage ever applied for or purchased insurance through IMG or IMG Europe Ltd.? If yes, please provide policy number and details: _____ | ❑ Yes ❑ No |
| 28. During the last twelve (12) months, have you or any family member applying for coverage been covered under any health or medical insurance plan? If yes, please state the name and location of the insurance company, the policy/plan number, and the applicable dates of coverage. | ❑ Yes ❑ No |

## PART 4 ADDITIONAL INFORMATION

| Question # | Name | Details/Diagnosis of Illness / Accident | Expenses in 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 5 *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.


© 2009-2021 International Medical Group, Inc. All rights reserved.

## PART 6 *** 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 Europe;

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 and IMG Europe 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 and IMG Europe Ltd., 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 Europe 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, IMG Europe 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 or IMG Europe Ltd.

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. and IMG Europe Ltd., 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 _____ | Date: ___/___/___ (DD/MM/YYYY) |
|---|---|
| Spouse's Signature: X _____ | Date: ___/___/___ (DD/MM/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

*GlobalSelect Group is a product underwritten by SiriusPoint International Insurance Corporation (publ.) (the "Insurer") and distributed, managed and by IMG Europe Limited ("IMG Europe").*

*IMG Europe Limited is authorised and regulated by the Financial Conduct Authority with registered number 302948. Contact address: Kingsgate, High Street, Redhill, Surrey RH1 1SH United Kingdom.*

*London Global S.r.l. trading as IMG Europe, authorised and regulated by IVASS, Italy (A000620496) and the Financial Conduct Authority (849073). Trading address Kingsgate, High Street, Redhill, Surrey RH1 1SH United Kingdom.*


© 2009-2021 International Medical Group, Inc. All rights reserved.
CM00501487A210813