

For organizations with 2-24 employees:

PART 3. Please answer the following questions. If your answer to any question is Yes, please give details in the space provided. Attach additional pages as necessary.		
1.	Has any employee or dependent suffered from an injury, illness or other medical/health condition that resulted in total claims, expenses, or costs of \$2,500 or more during the last three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are any employees or dependents currently hospitalized, confined at home or a treatment facility, disabled or incapacitated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are any employees or dependents currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Are any employees or dependents not able to work or perform activities of daily living due to illness, injury or other medical/health condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Are you aware of any circumstances, chronic, congenital, terminal, pre-existing, or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims, expenses, or costs for any employees or dependents?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART 4. CENSUS LISTING (For groups of less than 100 employees)									
Gender	Employee Name	Class*	Coverage Needed**	Date of Birth or Age	Occupation	Annual Salary***	# of Dependents Residing in U.S. or Canada	Citizenship	Country of Assignment

*Defined as a category of employees with easily distinguishable and identifiable common characteristics (i.e. management, non-management, hourly, salary, exempt, non-exempt, or sales)

**Status: Employee only (E) Employee+ Spouse (ES) Employee+ Child(ren) (EC) Employee+ Family (EF) (attach additional pages as necessary)

***Provide salary only if a proposal is desired for life insurance coverage based upon a multiple of salary

PART 5. CERTIFICATION	
<p>International Medical Group®, Inc., is authorized representative, and plan administrator of the insurance contract which may be issued by the insurance carrier. IMG or the insurance carrier may ask for more information, depending on the request, responses, and information later revealed. The undersigned plan administrator and/or authorized representative of the plan certifies all information shown on this form is correct and complete to the best of his or her knowledge and belief. It is understood IMG and the insurance carrier intend to rely on this information as part of the premium and coverage evaluation process. It is also understood if the information provided is not accurate, truthful, correct, and complete, IMG and the insurance carrier reserve the right to decline coverage, terminate coverage or revise premium rates accordingly. The plan and the undersigned acknowledge, understand, and agree 1) coverage is only offered to eligible participants whose applications are approved in writing by IMG and following timely receipt of premium owed and 2) this document is merely an invitation to inquire, not an application, and not a description of any losses for which benefits are payable.</p>	
Authorized Representative Contact:	Title:
Producer Name: Schellhaas and Associates	Agency Name:
Are You the Producer of Record? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Producer Signature:	Date (Day, Mo., Yr.):
IMG Producer Number (if contracted with IMG): 17073	Email: wshellhaa@aol.com
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