



- Groups with 50 or more employees
- All employees must complete Parts 1, 2 and 4
- All groups applying for life insurance must complete Part 3

PART 1

This application is for: I would like the following coverage:		<input type="checkbox"/> Single Coverage <input type="checkbox"/> New employee <input type="checkbox"/> Change of status <input type="checkbox"/> Address change	<input type="checkbox"/> Coverage to also include eligible dependents <input type="checkbox"/> Late enrollment <input type="checkbox"/> Beneficiary change <input type="checkbox"/> Name change	<input type="checkbox"/> Addition of dependent(s) <input type="checkbox"/> Removal of dependent(s) <input type="checkbox"/> Termination notice
Participating Organization:			Group I.D. Number:	
Employee Name: (Last)		(First)		(Middle)
Requested Effective Date:	Occupation:	Annual Salary:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address:			City:	
State, Zip:	Country, Telephone Number:		E-mail:	
Identification Number:	Date of Birth:	Social Security Number/Passport Number:		
Height:	Weight:	Date Employed Full-Time:	Hours Worked Per Week:	
Departure Date from U.S.:	Destination:		Length of Stay:	

I am enrolling dependents. **DEPENDENTS (attach a separate sheet, if needed)**

Name (Last, First, Middle)	Date of Birth & Date of Marriage to Spouse	HEIGHT	Identification Number
		WEIGHT	
Spouse			SS# PP#
Dependent Child #1 Sex: <input type="checkbox"/> M <input type="checkbox"/> F			SS# PP#
Dependent Child #2 Sex: <input type="checkbox"/> M <input type="checkbox"/> F			SS# PP#
Dependent Child #3 Sex: <input type="checkbox"/> M <input type="checkbox"/> F			SS# PP#

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

I refuse coverage for: Myself Spouse Children
 Reason: _____

I have been given the opportunity to participate in the group insurance plan offered through my employer and I have refused to participate in the coverage as indicated above. I understand that if coverage is desired at a later date, I may be required to furnish, at my own expense, satisfactory evidence of insurability before coverage becomes effective. **(SIGN HERE ONLY IF REFUSING COVERAGE)**

Signature: _____ Date: _____

Printed Name: _____

PART 2 **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 12 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. A copy of all applicable Certificates of Creditable Coverage

Note: Certificates of Creditable Coverage can be obtained from your prior insurer or employer. Any claims submitted without Certificates of Creditable Coverage will be processed with any pre-existing condition exclusion as defined by the Group Medical Insurance Master Policy.

Updated 05/04

**PART 3 BENEFICIARY INFORMATION -
FOR EACH INDIVIDUAL APPLYING FOR LIFE INSURANCE, PLEASE INDICATE:**

Primary Beneficiary Name _____	Relationship to Employee _____	Percent of Death Benefit _____ %
Contingent Beneficiary Name _____	Relationship to Employee _____	Percent of Death Benefit _____ %
Contingent Beneficiary Name _____	Relationship to Employee _____	Percent of Death Benefit _____ %

PART 4

SUBSCRIPTION I understand and agree: (i) that any misrepresentation or omission contained herein will void the insurance certificate, and any and all claims and benefits thereunder will be forfeited and waived, (ii) that IMG and the Company will rely on the accuracy and completeness of the information provided herein, (iii) that no coverage will be effective until this Application has been duly accepted in writing by the Company, (iv) that no modification or waiver relating to this Application or the coverage applied for will be binding upon the Company unless approved in writing by an officer of the Company, and (v) that the Master Policy is issued in the United States, and is governed by its laws.

CERTIFICATION I hereby certify, represent and warrant: (i) that I have read the above questions or they have been read to me, and I understand them, (ii) that my responses to the questions are true, accurate and complete in all respects, (iii) that I am (we are) currently in good health and, except for the conditions and other information disclosed herein, have not been diagnosed with, treated for, and do not suffer from any pre-existing condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance.

MEDICAL RELEASE I (we) authorize 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 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 such information to IMG and/or the Company.

Employee Signature _____ Date: _____

Spouse Signature _____ Date: _____

BENEFITS CHANGE INFORMATION

Effective Date (month/date/year) _____

Change of status (check one): Return to U.S. Date of return _____
 Return to overseas assignment Date of return _____