International Marine Medical Insurance℠ (IMMI)

Group Enrollment/Change Form

Late enrollees or groups with fewer than 25 covered employees must complete the entire form.
Groups with 25 or more employees must complete the entire form, excluding sections 4 and 5.
If you are modifying your Gold or Platinum plan, you must fill out the entire form, excluding sections 4 and 5.

International Marine Medical Insurance is a fully insured group benefit plan. The medical portion of the benefit plan is underwritten by Crum & Forster SPC, a member of the Crum & Forster Group of Companies and is available to members of the Fairmont Specialty Trust, LTD, c/o ITA Global Trust LTD, Camana Bay, Grand Cayman. The Life portion of the benefit plan is underwritten by International Medical Insurance Group via Alstead Re, a segregated cell company distributed, managed and administered, as agent for IMIG, by International Medical Group®, Inc. (IMG®).

1 GENERAL INFORMATION

This form is for:	☐ Employee Only Coverage ☐ Late Enrollment ☐ Beneficiary Change	☐ Name Change ☐ Coverage for Dependents ☐ Address Change	☐ Waiver of Coverage ☐ New Employee ☐ Termination (Initials:_____)	☐ Change of Status ☐ Removal of Dependent(s) ☐ Life Insurance Enrollment *(If requesting a life insurance amount of $100,000 or more, please fill out the questions in section 4)*

Participating Organization:				
Vessel Name:		Group/ Vessel I.D. Number:		
(A) Full Legal Name: *(Last, First, Middle)*				Citizenship:
Are you a U.S. citizen or resident required to file a U.S. tax return? ◯ Yes ◯ No		SSN/TIN:		Passport/ID Number:
☐ Male ☐ Female	Occupation:	Annual Salary: *(Required if applying for a life amount based on 1x, 2x, or 3x salary)*		Requested Effective Date: __/__/__ *(MM/DD/YYYY)*
Mailing Address:		City:		State/Country:
Postal/Zip Code:	Telephone:	Country of Residence:		
At the time of this application, are any applicants currently located in the state of New York? *(if yes, then the purchase of this plan is not available)* ◯ Yes ◯ No				
Date of Birth: __/__/__ *(MM/DD/YYYY)*	Height:	Weight:		Hours Worked per Week:
Date Employed Full-Time: __/__/__ *(MM/DD/YYYY)*	Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? ◯ Yes ◯ No			
Medicare ID Number:		Communication should be sent via email to:		

☐	I agree to the processing of my personal information to provide the services I have purchased, including to administer claims, and to receive member communications, in accordance with IMG's Privacy Policy, found at imglobal.com/legal/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.

2 WAIVER OF COVERAGE

I waive coverage for: ☐ Myself and Family Members ☐ Spouse ☐ Children

Reason:	Initials:	Date: __/__/__ *(MM/DD/YYYY)*

Note: *If you wish to apply for coverage for a person who is not waiving coverage, you must complete the rest of the enrollment form. Do not complete the rest of this form for anyone not applying for coverage.*

3 DEPENDENTS *(attach an additional form for more dependents)*

☐ I am enrolling dependents ☐ I am removing dependents

Name *(Last, First, Middle)*	1) **Date of Birth** 2) **Date of marriage to spouse or domestic partnership**	(H) Height (W) Weight	(MCN) Medicare Claim Number if enrolled and (SSN) Social Security Number	Passport Number
(A) Spouse:	1) __/__/__ *(MM/DD/YYYY)* 2) __/__/__ *(MM/DD/YYYY*	H: W:	MCN: SSN:	
(B) Child #1: ☐ Male ☐ Female	1) __/__/__ *(MM/DD/YYYY*	H: W:	MCN: SSN:	
(C) Child #2: ☐ Male ☐ Female	1) __/__/__ *(MM/DD/YYYY*	H: W:	MCN: SSN:	
(D) Child #3: ☐ Male ☐ Female	1) __/__/__ *(MM/DD/YYYY*	H: W:	MCN: SSN:	

If enrolling a newborn onto the plan, please answer the following questions:

Is the newborn you are currently requesting to enroll the result of in vitro fertilization (IVF) or any other type of a medically assisted conception?

Yes No

If so, please provide details, the name, and complete address of the physician or facility where treatment was rendered.

Did the mother or the father of the newborn receive any form of infertility treatment or other medical assistance designed to improve the likelihood of conception, including medication? Yes No

If so, please provide details of the treatment in addition to the name and complete address of the physician or facility where treatment was rendered.

4 MEDICAL QUESTIONS

The questions below must be accurately answered for all applicants. For any question answered "Yes," identify to whom the answer applies (use the letter that corresponds to the applicant from Parts 1 and 3), and provide complete details of the condition in Part 5, including the contact information for all medical providers and information related to the treatment. IMG and the Company reserve the right to request additional information following review of the answers.

1. Are you or any other applicant currently disabled, pregnant, or unable to work or perform activities of daily living?	Yes No
2. Are you or any other applicant presently hospitalized, 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), Lymphadenopathy 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 behavioral disorders, chemical or drug abuse or dependency, alcoholism, psychiatric counseling 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?	Yes No
7. Have you or any other applicant ever been rejected, cancelled, rated, or declined for coverage under any health, life, or disability insurance policy?	Yes No
8. During the last twelve (12) months, have you or any other applicant 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 ever had insurance through IMG at any time? If yes, please provide us with the policy or certificate number: _____ Your initials here will authorize IMG to cancel existing coverage under your current IMG insurance contract on the same date that your IMMI Group coverage becomes effective and only if the group coverage is approved. X _____	Yes No
10. Have you or any other applicant had COVID-19/SARS-CoV-2? a) Date diagnosed: __/__/__ *(MM/DD/YYYY)* b) Date of last treatment: __/__/__ *(MM/DD/YYYY))* c) Were you hospitalized? Yes No d) Were you in intensive care? Yes No e) Physician/hospital/clinic/health care provider name(s), address & telephone: _____ f) Condition(s)/diagnosis/prognosis/past and present course of treatment(s): _____	Yes No

Have you ever been treated for or been told that you have any illnesses, conditions, medical problems, disorders, or problems relating to any of the following? (Please explain all "yes" responses in section 5).

11. Hardening of the arteries or blood vessels	Yes No
12. Alcoholism or drug abuse	Yes No
13. Liver, stomach, intestine, thyroid, or gallbladder	Yes No
14. Kidney/sugar, protein, or blood in urine	Yes No
15. Asthma or other disease of the respiratory system	Yes No
16. Mental, nervous, or neurological	Yes No
17. Reproductive organs, including miscarriage or other complication of pregnancy or delivery	Yes No

18. Bone or skeletal, including any disorders of the knee, hip, or back	○ Yes ○ No
19. Migraine headaches or stroke	○ Yes ○ No
20. Colon or prostate (including testing or examination of the prostate gland)	○ Yes ○ No
21. Do you use tobacco in any form?	○ Yes ○ No
22. Any condition not listed above?	○ Yes ○ No

5 ADDITIONAL INFORMATION

Question #	Applicant	Condition(s)/Diagnosis and prognosis, past & present course of treatment	Expenses in the last 5 years	Dates of treatment *(MM/DD/YYYY)*	Medical provider name(s), address, & telephone
				__/__/__	
				__/__/__	
				__/__/__	
				__/__/__	
				__/__/__	

6 LIFE INSURANCE BASED ON MULTIPLE OF EMPLOYEE'S SALARY *(If applicable)*

Beneficiary Name	**Relationship**	**Birth Year** *(MM/DD/YYYY)*	**Percent of Benefit**
Primary Beneficiary #1:		__/__/__	
Primary Beneficiary #2:		__/__/__	
Contingent Beneficiary #1:		__/__/__	
Contingent Beneficiary #2:		__/__/__	

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7 CERTIFICATION AND AGREEMENT

1. The person(s) enrolling in this insurance (individually or collectively, "Applicant") represents that the responses provided in this enrollment form are true, accurate, and complete for all persons listed on this application, and that it will supplement such responses prior to the requested effective date in the event of any change or addition thereto; and that all persons listed on this application are not currently hospitalized, disabled, or HIV+ as of the requested effective date.

2. The Applicant understands and agrees that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of the applicant(s) and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) this insurance contains a number of exclusions from coverage, including an exclusion for any illness, injury, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment for which: medical advice, diagnosis, care or Treatment was recommended or received at any time during the three (3) months prior to the effective date or a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the three (3) months immediately preceding the Insured person's Initial Effective Date, (iii) the subjects of insurance applied for are not intended or considered by the Applicant, the Company or IMG to be resident, located, or expressly to be performed in any particular jurisdiction, and (iv) the Company, as carrier and underwriter of the insurance plan, is solely liable for the coverages and benefits to be provided under the insurance contract and IMG has no direct or independent liability under any insurance contract, (v) the Applicants also agree it is their responsibility to provide IMG with true, accurate and complete email address, contact, and other information related to my coverage, and to maintain and promptly update any changes in this information. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

3. The Applicant understands and agrees that, subject to Company's acceptance of this application and payment of the total amount due, coverage will begin at 12:01 a.m. on the approved effective date.

4. The Applicant agrees to receive information and communicate electronically, and prefers to use email rather than regular mail. The Applicant agrees that IMG may provide any communications in electronic format, and IMG is not required to send paper communications, unless and until the Applicant withdraws this consent. The Applicant also agrees to be responsible for providing IMG with true, accurate and complete email address, contact, and other information related to this insurance coverage, and to maintain and promptly update any changes in this information.

FRAUD NOTICE Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AUTHORIZATION FOR RELEASE OF INFORMATION The Applicant hereby authorizes any health plan, health care provider, health care professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to the Applicant or on the Applicant's behalf, has any records or knowledge of the Applicant's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the Applicant, and any non-medical information, to disclose Applicant's entire medical record, file, history, medications, and any other information concerning the Applicant and to give any and all such information to the Applicant's agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries.

Note: *When sending payment information, health information, and other documents and data regarding your confidential personal information, please send by secure means only.*

Employee Signature: **X** _____	Date: __/__/__ *(MM/DD/YYYY)*
Spouse Signature: **X** _____	Date: __/__/__ *(MM/DD/YYYY)*

Send by one of the following secure methods:

Secure Message Center: www.imglobal.com/secure-message-center
Fax: +1.317.655.4505

For other inquiries, contact IMG by:

Phone: +1.317.655.4500
Email: insurance@imglobal.com