

**PART 1**

<b>I would like to make the following changes to my coverage:</b>		<input type="checkbox"/> Addition of dependent(s)	<input type="checkbox"/> Change of status	<input type="checkbox"/> Termination notice
		<input type="checkbox"/> Beneficiary change	<input type="checkbox"/> Removal of dependent(s)	
		<input type="checkbox"/> Address change	<input type="checkbox"/> Name change	
Participating Organization:		Group I.D. Number:		
Employee Name: (Last)		(First)	(Middle)	
Requested Effective Date of Change:				
Street Address:		City:		
State, Zip:	Country, Telephone Number:		E-mail:	
Identification Number:	Date of Birth:	Social Security Number/Passport Number:		

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

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 <b>and the number of enrolled hours:</b>			

## PART 2

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

1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. During the last 24 months, have you or any family member applying for coverage been diagnosed with any medical condition or received any treatment (including medications or consultations) for any medical, mental, physical or nervous condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. During the last 24 months, have you or any family member applying for coverage been advised or recommended to have testing, treatment or surgery or do you anticipate testing, treatment or surgery for any medical, mental or nervous conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## PART 3

Have you or any family member applying for coverage ever suffered from, been treated for, or been told that you (they) have any disease, conditions, illnesses, medical problems, disorders sicknesses or other problems arising from, involving, or relating to any of the following? For any question that has been answered "Yes," please identify the family member to whom the answer applies, and provide complete details for the medical condition at issue in Part 4, including the name, address, and telephone number of all attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG reserves the right to request additional medical information.

1. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>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:</b>	
3. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Blood, blood vessels, arteries, veins or disorders of the blood, including, but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Diabetes, hyperglycemia or hypoglycemia? If Yes to diabetes, please complete the following: a) Diabetic Type: I ___ or II ___; Date diagnosed: _____ c) Controlled by diet only? Yes _____ No _____ d) Medications (Types / Dosage) _____ e) Date of most recent HbA 1c Test _____ f) Results of HbA 1c Test (1-10) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Cancer, tumor cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump or growth of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Kidney, urinary tract functions, kidney or bladder stones or infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	<input type="checkbox"/> Yes <input type="checkbox"/> No

10. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abused or dependency, alcoholism, psychiatric counseling and /or support groups, depression, anxiety, chronic fatigue, or eating disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice diagnosis or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Digestive system, stomach or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Eyes, ears, nose mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation chronic sinusitis, or TMJ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Any other disease, medical problem, illness, injury or condition of any kind not listed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Do you or any family member applying for coverage currently use or during the past 5 years have you used tobacco in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

**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 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.*

**PART 6 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 7**

**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):	<input type="checkbox"/> Return to U.S.	Date of return _____
	<input type="checkbox"/> Return to overseas assignment	Date of return _____