GlobalSelect® Group

International Healthcare Cover

25+ Employees

IMG Europe Limited
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Employer's Application & Claims Disclosure Statement

GlobalSelect Group is a product underwritten by Sirius International Insurance Corporation (publ) (the "Insurer"). Distributed, managed and administered as agent for and on behalf of the Company, by International Medical Group®, Inc. (IMG®) and IMG Europe Ltd.

The Employer must complete and return this form within 15 days prior to the effective date of coverage. This information will be treated as confidential by the Insurer, International Medical Group (IMG) and IMG Europe Ltd. No coverage will be effective for the Group or any Individuals within the Group until final approval is given for the complete Group by IMG or IMG Europe Ltd. The current coverage in force should not be cancelled prior to receiving written acceptance of coverage by IMG or IMG Europe Ltd.

Please complete this form and return it to IMG Europe Ltd with the: **If applicable and CPME applied for*

- ☐ Individual enrolment forms (and copies of current policy schedules/certificates of insurance)* for each person to be covered.
- ☐ Please check all forms are fully completed and signed before submitting to IMG Europe, as failure to submit full information may delay the requested Effective Date of the Group.
- ☐ Cheque payable to "**IMG Europe Ltd** "as a deposit towards the first month's premium (1/12th of estimated annual premium).

Note: All Applications and any responses to requests for additional information from IMG Europe, must be received by IMG Europe within 30 days of signature of this form. Failure to do so may delay the requested Effective Date of the Group

Prospective Policy Holder (The Employer)

Employer/Group/Participating Organisation Name:		Account Contact Person:	
Address:			
City:	County/Region/State:	Postal/Zip Code:	Country:
Telephone: +( ) -	Fax: +( ) -		E-mail:
Proposed Effective Date* : (On or within 30 days following Date of Signature)		Pay Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly	
Currency: ☐£ ☐€ ☐$		Amount of Deposit with Application:	
Total Number of Employees Applying for cover:	Total Number of Employees:		Total Number of Eligible Employees:

WAITING PERIOD FOR FUTURE EMPLOYEES JOINING IN RESPECT OF COVER FOR DECLARED AND ACCEPTED PRE-EXISTING MEDICAL CONDITIONS AND CHRONIC CONDITIONS (Unless agreed otherwise in writing by IMG Europe Ltd. or if Credit For Prior Coverage has been selected below and granted by IMG Europe Ltd):	**First of the billing month following 24 months of full-time employment**

Benefits Applied For

On behalf of the Employer/Group named above as the prospective Policy Holder, the Employer hereby applies to Sirius International Insurance Corporation (publ). for the following GlobalSelect Group coverages and benefits:

- if cover details for any members/sub groups will be different - please identify individual's area/level of cover and excess on census

(Census Attached? ☐ Yes ☐ No)

Geographical Area Of Cover (Tick one)	☐ **Area 1:** Europe ☐ **Area 4:** Tailor-made Area:	☐ **Area 2:** Worldwide excluding the USA and Canada		☐ **Area 3:** Worldwide ☐ **Mixed, refer to Census**
GlobalSelect Sub-Plan	☐ **HeadStart** ☐ **Tailor-made Coverage (See attached Schedule)**	☐ **Basic**	☐ **Standard**	☐ **Executive** ☐ **Mixed, refer to Census**
Medical Excess Level	____________ Per Insured Person, Per Condition, Per Period of Insurance			☐ **Mixed, refer to Census**
Underwriting (Refer to IMG Europe for definitions)	☐ **New Group** ☐ **Credit For Prior Coverage (towards standard wait periods)** **Name of Prior Carrier:**____________	☐ **Continuation of Personal Medical Exclusions (CPME)**		☐ **Take Over Provision** (6 month pre-existing look back, with credit for prior coverage and 12 month pre-existing wait period)
Underwriting Future New Group Joiners	☐ **Subject to Medical Underwriting and full Wait Periods** ☐ **Continuation of Personal Medical Exclusions (CPME)**			☐ **Credit For Prior Coverage**
Optional Additional Covers (Applicable to all Insureds)	**Global Personal Accident Plan** ☐ **Not Applied For** ☐ **One Unit of Cover** ☐ **Two Units of Cover** (ages 19-64)	**Global Daily Indemnity Cover – Hospital Income Plan** ☐ **Not Applied For** ☐ **Yes**		

Claims Disclosure Statement

The Employer is required to disclose in respect of all persons (Employees and Dependents) to be covered by this Plan.

If the Employer is not aware of this information tick 'No Known Claims' to confirm they are not aware of any personal medical information. Alternatively the Employer should answer all questions below to the best of their knowledge:		☐ No Known Claims
1.	Claims on any one participant (employee or dependent) during the immediately preceding 12 months which have been incurred, paid, pended or expected to exceed £5,000 / €7,500 / $10,000.	☐ Yes No ☐ ☐ No Known Claims
2.	Participants (employee or dependent) who are or are expected to be absent from work due to work related or non-work related disability on the effective date of coverage.	☐ Yes No ☐ ☐ No Known Claims

3.	Participants (employee or dependent) who are or have been pre-authorised or confined to a hospital or medical facility prior to the date of completion of this Statement, or who are suffering from a medical condition whereby they are planning or likely to result in a need for an in-patient hospital stay.	☐ Yes No ☐ ☐ No Known Claims
4.	Dependent children over 18 who are covered under the plan under a disabled or handicapped child extension provision.	☐ Yes No ☐ ☐ No Known Claims
5.	Participants with a history or a current diagnosis of any serious disease or disorder.	☐ Yes No ☐ ☐ No Known Claims
	Please advise if any person to be covered under this Plan (Employees and Dependents) have had previous treatment, or have treatment pending, or ongoing or have been advised to have diagnostic tests, treatment, hospitalisation or surgery for any of the following conditions:	
6.	Heart/Stroke Conditions.	☐ Yes No ☐ ☐ No Known Claims
7.	Any form of Cancer within the last 5 years.	☐ Yes No ☐ ☐ No Known Claims
8.	Psychiatric, Mental or Nervous Conditions.	☐ Yes No ☐ ☐ No Known Claims
9.	Organ Failure/Transplants.	☐ Yes No ☐ ☐ No Known Claims
10.	Any condition which is deemed incurable, chronic or requires long term treatment.	☐ Yes No ☐ ☐ No Known Claims
11.	Is any person to be covered under this Plan currently pregnant?	☐ Yes No ☐ ☐ No Known Claims
If the answer to any of the above is YES, please give full details below. Attach additional sheet if necessary.		

Group Claims Disclosure List

Name	EE / DEP	DOB	Diagnosis or nature of Disability, include current prognosis, treatment dates, drugs and dosages	Date Diagnosed/ Disabled	Expected Return to Work on	Claims paid last 12 months

☐ **Additional Group Claims Disclosure Statement & Continuation Form(s) Attached** ☐ **No Known Claims**

Declaration and Agreement:

Enclosed is payment of 1/12th of the estimated annual premium towards the first month's premium.
The Employer understands:

i. no coverage shall be effective unless and until notified in writing by IMG Europe Ltd that the Employer's application and all Enrolment Forms for all prospective members have been accepted by IMG Europe Ltd. for and on behalf of the Insurer,
ii. any such acceptance is at the sole discretion of IMG Europe Ltd. If the Employer's application is accepted, the enclosed deposit will be applied toward payment of the first monthly premium. If the Employer's application is not accepted, IMG's, IMG Europe Ltd's and the Insurer's sole obligation will be to return the deposit premium to the Employer,
iii. In the event premiums are not paid by the due date that cover will be automatically cancelled,
iv. as an employer employing persons in foreign jurisdictions, the Employer may be subject to foreign laws with respect to the provision of medical benefits and/or the insurance of those benefits, and agrees that neither the Insurer, nor IMG, nor IMG Europe Ltd. have investigated whether or how the purchase of this insurance complies with the laws of any foreign jurisdiction. The Employer further understands and agrees that Employer is solely responsible for compliance with all applicable foreign laws.

I/We hereby declare for and on behalf of the Employer, to the best of my knowledge that the information provided and Claims Disclosure Statement (or as attached), is complete, true and accurate and that nothing has been intentionally and/or negligently omitted. I/We understand and agree that this declaration will constitute part of the Employer's application and any misrepresentation, failure to provide sought for information or failure to disclose any material facts may result in the contract being void. (If you are in any doubt whether certain facts are material, these should be disclosed). I/We accept that any personal exclusions/limitations relating to an Insured Person's or potential Insured Person's existing cover may be maintained by IMG, IMG Europe and Insurers and this will be noted on an Endorsement to the Insured's Certificate of Insurance.

I/We further acknowledge and agree that this information may be used by International Medical Group (IMG), IMG Europe Ltd and the Insurer in determining the acceptability of the Employer's group's risk and that the information contained in this form may result in a change of rates quoted on the proposal. We understand that no coverage shall be provided unless specifically agreed to in writing by IMG or IMG Europe Ltd.

For Data Protection Act purposes I/We consent to IMG, IMG Europe and Insurers processing and holding sensitive data about the company and it's Employees/Dependents who apply to be included in the policy and for insurance administration purposes. The information may only be passed to selected third parties. I/We understand that all personal data supplied must be accurate and I/We have specific consent of those applicants to disclose their personal data. I declare that transfer by the Employer of personal data to IMG, IMG Europe Ltd., including information relating to employees insured under the Group Policy will not result in violating the Data Protection Act.

Signature of Authorised Employer Representative:____ Date:_______________

Printed Name:_______________________________________ Title/Position:____

This form must be signed by the Group Administrator

Agent Name: ____ Agent Number:______________

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International Healthcare Cover

25+ Employees

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Group Disclosure List *(Continued)*

Prospective Policy Holder (The Employer)

Employer/Group/Participating Organisation Name:		Account Contact Person:	
Address:			
City:	County/Region/State:	Postal/Zip Code:	Country:
Telephone: +( ) -	Fax: +( ) -		E-mail:

Group Claims Disclosure List Continued

Name	EE / DEP	DOB	Diagnosis or nature of Disability, include current prognosis, treatment dates, drugs and dosages	Date Diagnosed/ Disabled	Expected Return to Work on	Claims paid last 12 months

☐ **Additional Group Claims Disclosure Statement & Continuation Form(s) Attached** ☐ **No Known Claims**

Signature of Authorised Employer Representative:_______________________________ Date:_____________

Printed Name:___________________________ Title/Position:_______________________________

This form must be signed by the Group Administrator

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