ENROLLMENT FORM/CHANGE FORM Accident and Sickness Coverage

COMMUNITY INSURANCE AGENCY INC
QUALITY SERVICE TO THE COMMUNITY SINCE 1980

PLEASE COMPLETE THE APPLICATION AND SEND IT TO:
Community Insurance Agency, Inc.
425 Huehl Rd. Suite 22-A
Northbrook, IL 60062
Phone: 1-847-897-5120 or 1-800-344-9540
Fax: 1-847-897-5130
info@visitorsinsurance.com

IMG
INTERNATIONAL MEDICAL GROUP

PART 1: I would like the following coverage: ❑ Single Coverage ❑ Coverage to also include eligible dependents

This application is for: ❑ New Employee ❑ Late Enrollment ❑ Addition of Dependent(s) ❑ Change of Status
❑ Address Change ❑ Name Change ❑ Removal of Dependent(s) ❑ Termination Notice
❑ Beneficiary Change

Company Name:_____ Group Policy #:_____

EmployeeName:(Last)_____(First)_____(Initial)_____

Male ❑ Female ❑ Birth Date:_____ Social Security #:_____ Phone:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Country of Temporary Residence: _____ Requested Effective Date:_____

Date Employed Full-Time: _____ Hours Worked Per Week: _____ Occupation: _____

Dependents/Children *(attach additional sheet, if needed)*

Name of Dependent *(Last Name, First, Middle Initial)*	**Date of Birth and Date of Marriage to Spouse**	**Government Issued ID #**
Spouse ❑ M ❑ F		SS#
1st Child ❑ M ❑ F		SS#
2nd Child ❑ M ❑ F		SS#

For dependents children age 19 or older, please indicate name & address of the college or university plus the number of hours enrolled:

PART 2: Beneficiary Information

Beneficiary Name: _____ Relationship to Employee: _____

SUBSCRIPTION *I (we) hereby apply and subscribe to the Group Health, Accidental and Travel Insurance Trust, c/o Riggs National Bank, Washington, D.C., for the Specialty Group Accident & Sickness SM plan underwritten by Sirius International Insurance Corporation (publ) (the Company). I understand and agree: (i) the insurance applied for is not general health insurance, but is intended for my (our) use in the event of a sudden and unexpected illness or injury for which eligible coverage is available, (ii) coverage under the Plan is not renewable, (iii) I (we) must pay premiums for the entire period of coverage in advance, and no coverage will be effective until this Application has been accepted in writing by the Company, (iv) 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) the Master Policy is issued in the United States, and is governed by its laws.*

ACKNOWLEDGEMENT *I understand and agree that this insurance does not provide benefits or coverage for any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that existed at the time of application or at any time during the five years prior to the effective date of this insurance, including heart, cancer, tumor, blood vessel or circulatory system, and including any subsequent, chronic or recurring complications or consequences relating thereto or arising therefrom, whether or not previously manifested or known, diagnosed, treated, or disclosed (a "pre-existing condition"), and that all charges and/or claims for pre-existing conditions will be excluded from coverage under this insurance.*

MEDICAL RELEASE *I (we) hereby 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 for any physical or mental condition, or financial and employment status, to provide such information to IMG and/or the Company.*

CERTIFICATION *I hereby certify, represent and warrant that: (i) I have read the foregoing statements or they have been read to me, and I understand them. (ii) I am (we are) eligible to participate in this insurance program, (iii) I am (we are) currently in good health and have not been diagnosed with, treated for, and do not suffer from any pre-existing or other medical condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance. If signed as proxy of the Insured, the undersigned warrants their authority and capacity to so act and to bind the Insured. By acceptance of coverage or filing a claim, the insured ratifies the authority of the signatory to bind Insured.*

Employee Signature: X_____ Date: _____

Spouse Signature: X_____ Date: _____