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Group Employer Claims Disclosure Statement

Must be completed for all groups with 25 or more employees.

The Employer must complete and return this form at least 15 days prior to the proposed effective date of coverage. The Underwriting department will use this information to determine premium rates and decide whether to issue coverage. No coverage can or will be effective until all requested information is received and final approval is communicated in writing by IMG's Underwriting department. It would be prudent not to cancel any current inforce coverage prior to receiving written acceptance of the application, premium rates, and the effective date by IMG.

The employer is required to disclose:

1. Claims on any participant (i.e. employee or dependent) during the preceding 12 months which have been incurred, paid, pended or expected to exceed $5,000 USD.
2. Participants who are or are expected to be absent from work due to disability on the requested effective date
3. Participants who are or have been scheduled or confined to any medical facility prior to the reqested effective date
4. Dependent adult children who are disabled or handicapped and will be covered under the plan
5. Participants receiving coverage under any medical coverage continuation provision (e.g. COBRA); and
6. Participants who have been diagnosed with any serious disease or disorder.

Name	EE/DEP	D.O.B.	Date Disabled	Diagnosis or Nature of Disability	Expected to Return to Work Date	Medical Benefits paid last 12 months

☐ Additional Sheet(s) Attached

Decisions resulting from this inquiry are based solely on the completeness and accuracy of the information provided and may change based on additional information. Submission of this information does not guarantee any coverage will be approved. The carrier reserves the right to request additional documentation to verify eligibility. The undersigned plan administrator and/or sponsor certifies all of the information shown is correct and complete to the best of his or her knowledge. It is understood the carrier intends to rely on this information as part of the application and premium determination process. It is also understood if the information provided is not correct and complete, the carrier reserves the right to decline coverage, terminate coverage and/or revise premium rates accordingly. 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.

Employer Name:	Date:
Signature of Authorized Representative:	Title: