Insubuy®, Inc. 4200 Mapleshade Ln, Suite 200, Plano, TX 75093
Phone: (866) INSUBUY | Fax: (972) 767-4470 | info[at]insubuy.com

GEO℠ Group Enrollment/Change Form

Organizations with 25 or more employees

Insurance Company ("Company") GEO group insurance is underwritten and offered by:
(a) Sirius International Insurance Corporation (publ), and will be deemed issued and made in Hamilton, Bermuda, governed by Bermuda law, with sole and exclusive jurisdiction and venue for any legal proceeding relating to this insurance in Hamilton, Bermuda; or
(b) Certain Underwriters at Lloyd's, for Bahamas residents, governed by Bahamian law, with sole and exclusive jurisdiction and venue for any legal proceeding relating to this insurance in Nassau, Bahamas.

PART 1

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)
Participating Organization:		Group I.D. Number:	
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			
❑ Male ❑ Female	Occupation:	Annual Salary *(Required if applying for a life amount based on 1x, 2x, or 3x salary)*:	Requested Effective Date: *(month/day/year)*
Mailing Address:		City:	State/Country:
Postal/Zip Code:	Telephone:	Country of residence:	
Employee ID Number:	Date of Birth: *(month/day/year)*	Height:	Weight:
Date Employed Full-Time: *(month/day/year)*	Hours Worked per Week:	Departure Date from Country of Residence: *(month/day/year)*	Country of Assignment:
Length of Stay if applicable:	Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? ❑ Yes ❑ No		
Medicare Claim Number if enrolled in Medicare:		SSN/TIN:	Government Issued ID Number:
Communication should be sent via email to:			

WAIVER OF COVERAGE

I waive coverage for: ❑ Myself and Family Members ❑ Spouse ❑ Children	Reason:
Initials:	Date: *(month/day/year)*

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.*

DEPENDENTS *(attach an additional form for more dependents)* ❑ I am enrolling dependents ❑ I am removing dependents

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

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PART 2 LIFE INSURANCE based upon multiple of employee's salary *(if applicable)*			
❑ 1x Salary	❑ 2x Salary	❑ 3x Salary	❑ Other Amount:

By requesting life insurance and/or any future claim for life benefits I (we) purposefully initiate and take advantage of the privilege of conducting business with IMIC in Bermuda, through IMG as its managing general underwriter and plan administrator, the life insurance contract represented by its Master Policy and evidenced by that Certificate of insurance will be deemed, issued and made in Hamilton, Bermuda, and sole and exclusive jurisdiction and venue for any legal proceeding relating to the life insurance will be in Hamilton Bermuda, for which the applicant(s) hereby consent(s). I (we) consent and agree that Bermuda law shall govern all rights and claims raised under the life insurance contract.

EMPLOYEE BENEFICIARY INFORMATION			
Beneficiary Name	**Relationship**	**Birth Year**	**Percent of Benefit**
Primary Beneficiary #1:			
Primary Beneficiary #2:			
Contingent Beneficiary #1:			
Contingent Beneficiary #2:			

PART 3 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. This insurance contains a number of exclusions from coverage, including an exclusion for pre-existing conditions, and a complete copy of the insurance contract, including all exclusions, has been made available for review and agreement by the Applicant prior to this insurance becoming effective. The Applicant is currently in good health and has not been diagnosed with, sought consultation or been treated for, and has not experienced manifestation or symptoms of and does not suffer from any pre-existing or other medical condition which the Applicant foresees may require treatment during this insurance or for which the Applicant intends to claim under this insurance.

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.

Employee Signature:	Date: *(month/day/year)*
Spouse Signature:	Date: *(month/day/year)*

BENEFITS CHANGE INFORMATION: EMPLOYER USE ONLY		
Effective Date: *(month/day/year)*		
Change of Status *(Check one):*	❑ Return to the U.S. Date of Return: *(month/day/year)*	❑ Return to overseas assignment Date of Return: *(month/day/year)*