

# GeoCare Special Group Insurance Program

RUTHERFOORD INTERNATIONAL

## GEOCARE ENROLLMENT FORM

office use only

Group#

### GENERAL INFORMATION ON PRINCIPAL APPLICANT

Employee's Name (last name/first name/initial)		Home Country (principal residence)		Citizenship	
Employer's Name	Sex	Date of Birth(YY/MM/DD)	Height	Weight	Marital Status
Job Duties (description) / Title or Position		Salary (annual)	Date of Employment		Country of Assignment
Association & Membership number		Social Security or Citizenship number		telephone:	
				fax:	
Mailing Address (home country )			Mailing Address (country of assignment)		
			e-mail (if available):		

### ELECTED COVERAGE

<b>Comprehensive Major Medical</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Term Life</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Dental Care</b>	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>AD &amp; D</b>	<input type="checkbox"/> yes <input type="checkbox"/> no
		<b>Long Term Disability</b>	<input type="checkbox"/> yes <input type="checkbox"/> no

### LIFE - AD & D - LTD

Amount of Life Insurance \$	Amount of Accidental Death Insurance \$	Mailing Address of Beneficiary
Name of Beneficiary	Relationship to Insured Age	
Amount of Long Term Disability Income (provide proof of salary or income, W-2 form or pay stub) \$	Waiting Period for Long Term Disability <b>60</b> days	

### GENERAL INFORMATION ON COVERAGE

Name of current or previous Health insurance coverage (Company & Dates): \_\_\_\_\_

Is your spouse employed?  yes  no

Do you have, or are you eligible for any other insurance or government program?  yes  no

If yes, indicate the source: \_\_\_\_\_

Are any dependents to be insured?  yes  no

Name: last name, first name, initial	Sex	Date of Birth	Height	Weight	Address (if different from Principal Insured)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

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### QUESTIONNAIRE FOR MEDICAL (TO BE COMPLETED BY ALL INDIVIDUALS TO BE INSURED)

#### Please answer the following questions

- 1) Do you have any physical defect, infirmity or any other circumstances of your occupation, habits or bodily powers which might render you specially liable to accident, disability, care or treatment? Yes  No
- 2) During the last two years, have you ever been hospitalized, consulted a medical practitioner or received treatment for any medical condition such as:
- |                              |  |                               |  |                                 |  |
|------------------------------|--|-------------------------------|--|---------------------------------|--|
| Heart disease                | Yes <input type="checkbox"/> No <input type="checkbox"/> | Blood Pressure / Hypertension | Yes <input type="checkbox"/> No <input type="checkbox"/> | Cancer                          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes                     | Yes <input type="checkbox"/> No <input type="checkbox"/> | AIDS or any related disease   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Venereal disease                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Respiratory Problems         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Mental or Nervous disorder    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Malaria and Bacterial Infection | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chronic or Recurring Illness | Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid or Endocrine disease  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Other Medical Conditions        | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If you have answered YES to any of the above questions, please give full details below, including the condition, treatment, dates and time absent of work. If there is not enough space, please continue on a separate sheet.

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### DECLARATION

It is understood that the term "Insurer" used hereafter replaces Capital Life Insurance Company, Ltd.:

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I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief, and I understand that the answers to the above questions shall be the basis of any coverage issued, and that any incorrect answers may void this insurance.

In the event of my death while insured, any death benefit payable under the coverage issued through my Association by the Insurer shall be paid in accordance with the beneficiary designation above. I hereby request to participate under my Association's Group Plan and this request, all elections and authorizations shall remain in effect until I change them in writing.

Only eligible family members listed above may become insured.

I understand that insurance benefits may be limited or excluded for conditions for which a family member (including myself) has received any medical diagnosis or treatment or taken any medication or where distinct symptoms were evident prior to his or her effective date, according to the pre-existing conditions limitation provisions of the Plan.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, consumer reporting agency, insurance or reinsuring company, or employer having certain information about me, my spouse and/or my children to give to the Insurer, or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes information about physical conditions, health histories, avocations, ages, occupations, and personal characteristics. This authorization includes information about drugs, alcoholism or mental illness.

I understand the information obtained by use of the Authorization will be used by the Insurer to determine eligibility for insurance and eligibility for benefits. I also authorize the Insurer to release any information obtained to reinsuring companies or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I agree this Authorization shall be valid for two and one-half years from the date shown below. I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original.

APPLICANT'S NAME \_\_\_\_\_

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_