

## Enrollment Form

### PART 1

<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family
Vessel/Company Name:		<input type="checkbox"/> \$3,000 deductible	<input type="checkbox"/> \$5,000 deductible
Employee Name: (Last)	(First)	(Middle)	
Position on Vessel:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height:      Weight:
Address:			
Country:	Country of Citizenship:	Telephone:	
Social Security or Passport #:		Issuing Country:	
Date of Birth: (mm / dd / yy)	Requested Effective Date: (mm / dd / yy)	VIPCA Membership ID Number and Start Date:	

### PART 2

DEPENDENT INFORMATION (Attach a separate sheet, if needed.)				
Name (Last, First, Middle)	Date of Birth and Date of Marriage for Spouse	Height and Weight	Social Security Number/Passport	Country of Citizenship
Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female				
1 <sup>st</sup> Child <input type="checkbox"/> Male <input type="checkbox"/> Female				
2 <sup>nd</sup> Child <input type="checkbox"/> Male <input type="checkbox"/> Female				
3 <sup>rd</sup> Child <input type="checkbox"/> Male <input type="checkbox"/> Female				
For dependent children age 19 or older, please indicate name and address of college or university and number of hours enrolled:				

### PART 3

<b>CURRENT COVERAGE INFORMATION</b> (Please provide a copy of the benefit summary if possible)
Current Carrier Name:
Current Carrier Policy Number:
Current Carrier Phone Number:
Current Subscriber:
Effective/Termination Dates:

### PART 4

I hereby certify that I have read the above statements and all attachments or they have been read to me and the statements are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained herein will void the insurance and all claims will be forfeited. I understand that no coverage is effective until I am notified in writing by the Company, and the Company has the right to refuse to grant coverage. The undersigned authorizes any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policy holder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial and employment status of the individual to provide this information to CIGNA Global Medical.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(mm / dd / yy)

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(mm / dd / yy)