

Request for Proposal

Group/Organization Name _____ Contact Person _____

Telephone _____ Fax _____ E-mail _____

Nature of Industry _____

Street Address _____

City _____ State/Province _____ Country _____ Postal Code _____

Fully insured _____ Stop Loss _____ ASO _____

Requested Effective Date _____ (must begin on 1st of month)

Total number of international assignees (expatriates, third country nationals, key local nationals) _____

Total number of U.S. citizens _____

Is the company/organization a subsidiary or division of a U.S. or Canadian corporation? Yes No

Are any employees/dependents currently residing in the U.S. or Canada? Yes No If yes, how many? _____

(If yes, please list those employees separately on the census listing.)

Does applicant currently have group medical insurance? Yes No

(If yes, please provide name of carrier, current and renewal rates, schedule of benefits, and claims experience.)

Has another insurance company refused to quote on this group? Yes No

Are any employees or dependents presently on COBRA? Yes No

(If yes, please list those employees separately on the census listing.)

Agency _____ Agent Name _____ IMG Agent # _____

Address _____

City _____ State/Province _____ Country _____ Postal Code _____

Telephone _____ Fax _____ E-mail _____

REQUESTED PLAN OF BENEFITS

Deductible	Max. Deductible	Lifetime Maximum	Life Insurance Benefit
<input type="checkbox"/> \$100	<input type="checkbox"/> 2 per family	<input type="checkbox"/> \$1,000,000 (Std)	<input type="checkbox"/> \$25,000
<input type="checkbox"/> \$250	<input type="checkbox"/> 3 per family (Std)	<input type="checkbox"/> \$5,000,000	<input type="checkbox"/> \$50,000
<input type="checkbox"/> \$500			<input type="checkbox"/> 1 X's Salary to a Maximum of \$ _____
<input type="checkbox"/> \$1,000			<input type="checkbox"/> 2 X's Salary to a Maximum of \$ _____
<input type="checkbox"/> \$2,500			<input type="checkbox"/> 3 X's Salary to a Maximum of \$ _____
<input type="checkbox"/> \$5,000			

Please answer the following questions. If your answer to any question is yes, please give details in the space provided. Attach additional pages as necessary.

- Has any employee or dependent suffered from an injury, illness or other medical/health condition that resulted in total claims of US\$2,500 or more during the last three years? Yes No
- Are any employees or dependents currently hospitalized, confined at home or a treatment facility, disabled or incapacitated? Yes No
- Are any employees or dependents currently pregnant? Yes No
- Are any employees or dependents not actively at work performing his/her normal duties due to illness, injury or other medical/health condition? Yes No
- Are you aware of any circumstances, chronic or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims for any employees or dependents? Yes No

