GlobalSelect® Group International Healthcare Cover

Request for Group Quotation

IMG Europe Limited
36-38 Church Road, Burgess Hill,
West Sussex, RH15 9AE,
United Kingdom
Tel : +44 (0) 1444 46 55 55
Fax : +44 (0) 1444 46 55 50
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In order for IMG Europe to provide an indication of premium for a group, please complete this form and send to IMG Europe.

Completed By : ☐ **Group** ☐ **Broker** ☐ **IMG Europe**

1. Details Of Group/Organisation

Group/Organisation Name	Nature of Industry/Business	Requested Effective Date	Contact Person
Telephone	Fax	E-Mail	Website
Address			Country

Intermediary/Broker Details
Intermediary Name : **IMG/E Intermediary Number** **Are You the Broker of Record** **Yes**

2. About the group to be Insured

Total number of international staff/dependents to be insured
(i.e. expatriates, third country nationals, key local nationals)? Staff Members: _____ + Dependents: _____ = _____ Total Lives

Has any Insurance company refused to quote on this group? No / Yes | Preferred Quote/Plan Currency £ GB Pound / US$ / EU€

Does the group currently have medical insurance No / Yes

If yes, please provide details of insurer, current and renewal rates, schedule of benefits and claims experience.

Insurer _____ Current rate £ / $ / €/ ____not sure_____

Plan (Attach benefit schedule / No) _____ Renewal Rate Offered £ / $ / € _____ not sure _____

Claims Experience Available / Not Available Best Rate Offered (like terms) £ / $ / € _____ not sure _____

3. Basis of Group Transfer Application

Tick as appropriate

Group Transfer Provisions are only available to groups currently insured with a different medical insurance provider's plan that would like to apply to transfer to GlobalSelect. (Applies only to employees/dependents who are covered under prior plan immediately preceding the effective date of this cover.) Note : New enrolees will be subject to all wait periods, unless otherwise agreed by IMG Europe in writing. Please select one of the following basis under which the Group is interested in transferring its existing group medical insurance to GlobalSelect:

Underwriting Basis (Refer to IMG Europe for definitions)	☐ **Newly Insured Group** ☐ **Continuation of Personal Medical Exclusions (CPME)** ☐ **Take Over Provision** (6 **month pre-existing look back, with credit for prior coverage and** pre-existing wait period reduced to 12 month) ☐ **Credit For Prior Coverage (towards standard wait periods)** **Name of Prior Carrier:**_____
Underwriting Future New Group Joiners	☐ **Subject to Medical Underwriting and full Wait Periods** ☐ **Credit For Prior Coverage** ☐ **Continuation of Personal Medical Exclusions (CPME)**

3. Requested Cover Details – Applicable to all group members

- if cover details for any members/sub groups will be different - please identify individual's area/level of cover and excess on census

3.1 Select the Geographical Area Of Cover (Tick one)	☐ **Area 1 :** Europe
	☐ **Area 2 :** Worldwide excluding the USA, Canada, China, Hong Kong, Macau, Japan, Singapore and Taiwan
☐ Mixed (10+ Employees) : Refer to Census	☐ **Area 3 :** Worldwide
	☐ **Other - Custom Area :** _____

Questions relating to US citizens and Cover in the USA:

How many individuals reside in the USA or Canada?	How many U.S. citizens are in the group?	How many U.S. citizens in the group reside in the USA?

3.2 Select Which Plan(s) and Level(s) Of Excess you would like quotes for -If you require tailor-made cover please contact us

☐ Mixed (10+ Employees) : Refer to Census

HeadStart Plan	Basic Plan	Standard Plan	Executive Plan
☐ **£100/$180/€150 – Standard Excess**	☐ **£100/$180/€150 – Standard Excess**	☐ **£50/$90/€75 - Standard Excess**	☐ **£25/$45/€38 - Standard Excess**
OR… Voluntary Medical Excess Options: The voluntary excess options do not apply to the optional add-ons plans or to non-medical sections of cover.			
☐ **N/A**	☐ **N/A**	☐ **Nil Excess**	☐ **Nil Excess**
☐ **N/A**	☐ **N/A**	☐ **N/A**	☐ **£50/$90/€75 Excess**
☐ **N/A**	☐ **N/A**	☐ **£100/$180/€150 Excess**	☐ **£100/$180/€150 Excess**
☐ **£250/$450/€375**	☐ **£250/$450/€375**	☐ **£250/$450/€375**	☐ **£250/$450/€375**
☐ **£500/$900/€750**	☐ **£500/$900/€750**	☐ **£500/$900/€750**	☐ **£500/$900/€750**
☐ **£1,000/$1,800/€1,500**	☐ **£1,000/$1,800/€1,500**	☐ **£1,000/$1,800/€1,500**	☐ **£1,000/$1,800/€1,500**
☐ **£2,500/$4,500/€3,750**	☐ **£2,500/$4,500/€3,750**	☐ **£2,500/$4,500/€3,750**	☐ **£2,500/$4,500/€3,750**
☐ **£5,000/$9,000/€7,500**	☐ **£5,000/$9,000/€7,500**	☐ **£5,000/$9,000/€7,500**	☐ **£5,000/$9,000/€7,500**
☐ **£10,000/$18,000/€15,000**	☐ **£10,000/$18,000/€15,000**	☐ **£10,000/$18,000/€15,000**	☐ **£10,000/$18,000/€15,000**

4. Optional Covers – Applicable to all group members

*Delete as appropriate

Do you require quotes for Global Personal Accident Plan and/or Global Daily Indemnity – Hospital income Plan?	No, 1 or 2 unit(s)*	**Global Personal Accident Plan**
	No / Yes*	**Global Daily Indemnity – Hospital Income Plan**

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Claims Disclosure Statement

The Employer is required to disclose in respect of all persons (Employees and Dependents) to be covered by this Plan. If the answer to any of the following questions is yes, please give details in the space provided. Attach additional pages as necessary. Where this section is left blank and/or not completed by the Group Administrator, then the quotation will be on the basis that all sections below would have been answered 'no' and any subsequent information or 'yes' answer may alter the final quotation and may affect the acceptability of certain individuals within the group. Final rates and cover will be based upon the actual enrolment, including evidence of insurability/previous provider's cover/terms.

If the Employer is not aware of this information tick 'Don't Know' to confirm they are not aware of any personal medical information. Alternatively the Employer should answer all questions below to the best of their knowledge:			**☐ Don't Know**
1.	Claims on any one participant (employee or dependent) during the immediately preceding 12 months which have been incurred, paid, pended or expected to exceed £5,000 / €7,500 / $10,000.	☐ Yes ☐ No	☐ Don't Know
2.	Participants (employee or dependent) who are or are expected to be absent from work due to work related or non-work related disability on the effective date of coverage.	☐ Yes ☐ No	☐ Don't Know
3.	Participants (employee or dependent) who are or have been pre-authorised or confined to a hospital or medical facility prior to the date of completion of this Statement, or who are suffering from a medical condition whereby they are planning or likely to result in a need for an in-patient hospital stay.	☐ Yes ☐ No	☐ Don't Know
4.	Dependent children over 18 who are covered under the plan under a disabled or handicapped child extension provision.	☐ Yes ☐ No	☐ Don't Know
5.	Participants with a history or a current diagnosis of any serious disease or disorder.	☐ Yes ☐ No	☐ Don't Know
Please advise if any person to be covered under this Plan (Employees and Dependents) have had previous treatment, or have treatment pending, or ongoing or have been advised to have diagnostic tests, treatment, hospitalisation or surgery for any of the following conditions:			
6.	Heart/Stroke Conditions.	☐ Yes ☐ No	☐ Don't Know
7.	Any form of Cancer within the last 5 years.	☐ Yes ☐ No	☐ Don't Know
8.	Psychiatric, Mental or Nervous Conditions.	☐ Yes ☐ No	☐ Don't Know
9.	Organ Failure/Transplants.	☐ Yes ☐ No	☐ Don't Know
10.	Any condition which is deemed incurable, chronic or requires long term treatment.	☐ Yes ☐ No	☐ Don't Know
11.	Is any person to be covered under this Plan currently pregnant?	☐ Yes ☐ No	☐ Don't Know

If the answer to any of the above is YES, please give full details below. Attach additional sheet if necessary.

5. Group Member Details

Please list each person to be covered under this Policy (you may attach a schedule/census if this is more convenient): **Tick if census attached** ☐
Alternatively for group of 100+ lives, you may complete the Census Summary below. **- Please include the info below**

Name	Sex	Date of Birth	Nationality	Country of Residence	Insured Type* **EE / S / D / SP**

***Insured Type Key** : Employee (**EE**), Spouse (**S**), Dependent Child - Under 23 if in full time education (**D**), Single Parent/Employee (**SP**) and list all D's

Census Summary – For Group of 100+ lives : Please indicate the number of each Insured units **Tick if census attached** ☐
: NOT required if a full census has been provided containing Name, Sex, Age/Date of Birth, Nationality, Country of Residence and Insured Type
i.e. an Employee and Spouse would be ONE "EE+Spouse" unit, and Employee with Spouse and children would be ONE "EE+ Spouse+Children" unit, EE Only + Child(ren) refers to one parent families or where no cover is required for the spouse, but is required for the employee and their children.

Age	**MALE Employee**				**FEMALE Employee**			
	Employee (EE)	EE + Spouse	EE + Spouse +Child(ren)	EE Only +Child(ren)	Employee (EE)	EE + Spouse	EE + Spouse + Child(ren)	EE Only + Child(ren)
18-24								
25-29								
30-34								
35-39								
40-44								
45-49								
50-54								
55-59								
60-64								
65-69								
70+								

As representative for the Group named above, I hereby declare to the best of my knowledge that the information, including any attachments provided, is complete, true and accurate. I agree this information will constitute part of the company's application and be the basis upon which IMG Europe Ltd. provide premium and cover indications. I understand that failure to disclose any material facts may result in the contract being void. (If you are any doubt whether certain facts are material, these should be disclosed).

Signed : _____ **Dated** : ___/___/___

Name : _____ **Title** : _____

(This form must be completed and signed by the Group Administrator for and on behalf of all Members/Applicants)