

International Medical Group<sup>SM</sup>, Inc.  
 407 Fulton Street  
 Indianapolis, Indiana 46202 USA  
 Phone: 800.628.4664 (In US) ext. 4536  
 317.655.4536 (Outside US)  
 Fax: 317.655.4505 Attn: Group Benefits  
 Email: geoinfo@imglobal.com



## Request for Proposal

Group/Organization Name \_\_\_\_\_ Contact Person \_\_\_\_\_  
 Telephone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_  
 Nature of Industry \_\_\_\_\_ SIC \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

Requested Effective Date \_\_\_\_\_ (must begin on 1<sup>st</sup> of month) Requested Commission \_\_\_\_\_ %  
 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/or 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**

<b>Deductible</b>	<b>Max. Deductible</b>	<b>Lifetime Maximum</b>	<b>Life Insurance Benefit</b>
<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

