# MP+International
## Request for Proposal

IMG

| PART 1. | | | |
|---|---|---|---|
| Participating Organization Name: | | Authorized Representative Contact: | |
| Telephone: | Fax: | Email: | |
| Street Address: | | | City: |
| State/Province: | Country: | Postal/Zip Code: | Requested Effective Date: *(Day, Mo., Yr.)* |
| Nature of Business: | | Type of Work Employees Perform: | |
| Total Number of International Employees: | Total Number of Eligible International Employees: | Total Number of U.S. Citizens Included in the International Employee Count: | Total Number of Local Nationals Applying: |

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|---|---|
| Is the company/organization a subsidiary or division of a U.S. or Canadian corporation? If Yes, U.S. or Canadian? | ☐ Yes ☐ No |
| Are any employees/dependents currently residing in the U.S. or Canada? If Yes, please provide details in census section. | ☐ Yes ☐ No |
| Do you expect the number of employees to vary in the next 12 months? If Yes, please provide details. | ☐ Yes ☐ No |
| Have any covered employees and appointed representatives been employed for less than 6 months? If yes, how many? _____ | ☐ Yes ☐ No |
| Does the company currently have or offer medical insurance? If Yes, please provide name of carrier, current and renewal rates, schedule of benefits, and claims experience. | ☐ Yes ☐ No |
| Has another insurance company refused to quote, terminated, or declined to offer coverage to the organization or its participants? If Yes, please provide details. | ☐ Yes ☐ No |
| Are any employees or dependents presently covered under COBRA or other continuation plans? If Yes, please indicate those individuals in the census. | ☐ Yes ☐ No |
| If local nationals are applying for coverage, will the employees be travelling outside of their country of residence? If Yes, how often? For how long? | ☐ Yes ☐ No |

## PART 2. REQUESTED PLAN BENEFITS

Non-U.S. Deductible: ☐ $0 ☐ $100 ☐ $250 ☐ $500 ☐ $750 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other: $_____

U.S. Deductible: ☐ $0 ☐ $100 ☐ $250 ☐ $500 ☐ $750 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other: $_____

Coverage Plan: ☐ Standard ☐ Alternative

Maximum Deductible: ☐ 2 per Family ☐ 3 per Family

Coverage Area *(Choose One)*: ☐ Worldwide ☐ Custom – Please indicate countries covered:_____
☐ Worldwide Excluding* the U.S., Canada, China, Hong Kong, Japan, Macau, Singapore and Taiwan
**Except 30 days emergency/accident*

Additional Benefits Upon Request: ☐ Platinum USA Benefit Rider ☐ Other:_____ ☐ Daily Hospital Indemnity
☐ Creditable Coverage Offset ☐ Guarantee Issue for New Employees ☐ AD&D
☐ Dental 1 ☐ Dental 2 ☐ Dental 3

Lifetime Maximum: ☐ $1,000,000 ☐ $5,000,000 ☐ $8,000,000 ☐ Other: $_____

Life Insurance Benefit: (Optional) ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ 1 x Salary to maximum of $_____
☐ 2 x Salary to maximum of $_____ ☐ 3 x Salary to maximum of $_____
☐ Other $_____

Implementation needs: ☐ Reporting _____

☐ Enrollment _____

## PART 3. REQUESTED SERVICES (ADDITONAL ASSISTANCE SERVICES UPON REQUEST)

☐ Medical Security Evacuation Services ☐ Travel Intelligence Portal ☐ Remote Mental Health Services ☐ Teleconsultation

**For organizations with 2-24 employees:**

| **PART 4. 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.** | |
|---|---|
| 1. Has any employee or dependent suffered from an injury, illness or other medical/health condition that resulted in total claims, expenses, or costs of $2,500 or more during the last three years? | ☐ Yes ☐ No |
| 2. Are any employees or dependents currently hospitalized, confined at home or a treatment facility, disabled or incapacitated? | ☐ Yes ☐ No |
| 3. Are any employees or dependents currently pregnant? | ☐ Yes ☐ No |
| 4. Are any employees or dependents not able to work or perform activities of daily living due to illness, injury or other medical/health condition? | ☐ Yes ☐ No |
| 5. Are you aware of any circumstances, chronic, congenital, terminal, pre-existing, or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims, expenses, or costs for any employees or dependents? | ☐ Yes ☐ No |

**PART 5. CENSUS LISTING (For groups of less than 100 employees)**

| Gender | Employee Name | Class* | Coverage Needed** | Date of Birth (MM/DD/YYYY) | Occupation | Annual Salary*** | # of Dependents Residing in U.S. or Canada | Citizenship | Country of Assignment |
|---|---|---|---|---|---|---|---|---|---|
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**Defined as a category of employees with easily distinguishable and identifiable common characteristics (i.e. management, non-management, hourly, salary, exempt, non-exempt, or sales)*

***Status: Employee only (E) Employee+ Spouse (ES) Employee+ Child(ren) (EC) Employee+ Family (EF) (attach additional pages as necessary)*

****Provide salary only if a proposal is desired for life insurance coverage based upon a multiple of salary*

**PART 6. CERTIFICATION**

International Medical Group®, Inc., is authorized representative, and plan administrator of the insurance contract which may be issued by the insurance carrier. IMG or the insurance carrier may ask for more information, depending on the request, responses, and information later revealed. The undersigned plan administrator and/or authorized representative of the plan certifies all information shown on this form is correct and complete to the best of his or her knowledge and belief. It is understood IMG and the insurance carrier intend to rely on this information as part of the premium and coverage evaluation process. It is also understood if the information provided is not accurate, truthful, correct, and complete, IMG and the insurance carrier reserve the right to decline coverage, terminate coverage or revise premium rates accordingly. The plan and the undersigned acknowledge, understand, and agree 1) coverage is only offered to eligible participants whose applications are approved in writing by IMG and following timely receipt of premium owed and 2) this document is merely an invitation to inquire, not an application, and not a description of any losses for which benefits are payable.

| | |
|---|---|
| Authorized Representative Contact: | Title: |
| Producer Name: | Agency Name: |
| Are You the Producer of Record? ☐ Yes ☐ No | |
| Producer Signature: | Date *(Day, Mo., Yr.)*: |
| IMG Producer Number (if contracted with IMG): | Email: |
| Telephone: | Fax: |

**Send by one of the following secure methods:**
**Secure Message Center:** www.imglobal.com/secure-message-center
**Encrypted Email:** insurance@imglobal.com

**Fax:** +1.317.655.4505
**For other inquiries call:** +1.317.655.4500