Group International Health Insurance Plan

Request for Proposal

Please complete the following request for proposal, sign and return back to us via email or fax. Once received, we can provide a detailed quote from multiple insurance companies. Our expert agents will then walk you through your various options and help you to select the best plan for your organization. If you need assistance, please contact us:

Website: www.internationalinsurance.com/groups	Email: info@internationalinsurance.com
Telephone: US 877-758-4881 Int'l +1 617-500-6738	Fax: US 617-505-1484

PART 1. ORGANIZATIONAL INFORMATION			
Group/Organization Name:		Contact Person:	
Tel:	Fax:	Email:	
Street Address:		City:	
State/Province:		Country:	Postal Code:
Requested Effective Date *(DD/MM/YYYY)*:			
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:	
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
Does the company currently have group 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 on this group? If Yes, please provide details.			☐ Yes ☐ No

Are any employees or dependents presently covered under COBRA continuation? If Yes, please indicate those employees on census.	☐Yes ☐No
If local nationals are applying for coverage, will the employees be travelling outside of their home country? If Yes, how often? For how long?	☐Yes ☐No

PART 2. REQUESTED PLAN BENEFITS

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

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

Coverage Area (Choose One):

☐Worldwide

☐Worldwide Excluding* the U.S., Canada, China, Hong Kong, Japan, Macau, Singapore and Taiwan, or

☐Custom – Please indicate countries covered: _____

**Except 30 days emergency/accident*

Additional Benefits Upon Request:

☐Maternity Rider ☐Adventure Sports Rider

☐USA Benefit Rider *(Enhanced benefits in line with US style plans)*

☐Long-term Disability *(Please complete Disability Questionnaire)*

☐Prescription Drug Card *(U.S. pharmacies only)*

☐Daily Indemnity ☐Dental/Vision ☐Continuation Rider ☐Other: _____

Life Insurance Benefit*: ☐$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 $ _____

** (2-10 lives, $10,000 minimum required). Maximum available guaranteed issue is $100,000.*

PART 3. Please answer the following questions. If your answer to any question is Yes, please give details in the space provided. Attached 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 $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

PART 4. CENSUS SUMMARY (Enter # for each category; required for groups of 100 lives or more)

AGE	MALE				FEMALE			
	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
19-24								
25-29								
30-34								
35-39								
40-44								
45-49								
50-54								
55-59								
60-64								
65-69								
70+								

CENSUS LISTING (For groups of less than 100 employees; attach additional pages as necessary)

Gender (M / F)	Employee Name	Class*	Status**	Date of Birth or Age	Occupation	Annual Salary***	# of Dependents Residing in U.S. or Canada	Nationality	Country of Assignment

*Defined as a group 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)

***Provide salary only if applying for 1x, 2x, or 3x salary for life insurance

PART 5. AUTHORIZATION

The undersigned representative for the within named Group hereby certifies, represents and warrants that the information provided on this Request for Proposal, including any attachments, is true, accurate and complete in all respects and acknowledges that such information is intended to provide International Citizens Group, Inc. with information necessary to evaluate this Group and provide the Group with premium and coverage indications. Final rates and coverage will be based on actual enrollment, including evidence of insurability.

Applicant Signature:	Date:
Printed Name:	Title:

AGENCY CONTACT INFORMATION

Agency Name: International Citizens Group, Inc.	Contact Name: Joe Cronin
Website: https://www.internationalinsurance.com/	Email: info@internationalinsurance.com
Telephone: US 877-758-4881 Int'l +1 617-500-6738	Fax: US 617-505-1484