



Please tell us about your company...

Desired Effective Date: _____ / _____ / _____

Company Name: _____

Address: _____

City / State / Zip: _____

Country / Postal Code: _____

Contact Person: _____ Phone #: (____) _____

Website (optional): _____ Fax #: (____) _____

Type of Business: _____ E-mail: _____

Medical Coverage Preferences...

Maximum Limit Option \$1,000,000 Lifetime \$5,000,000 Lifetime Other \$ _____

Individual Deductible Options \$150 \$250 \$500 \$1,000 \$2,500 \$5,000

Waiting Period - New Employees 0 Days 30 Days 60 Days 90 Days Other _____ Days

Term Life Face Amount \$10,000 \$25,000 \$50,000 Other \$ _____

Takeover Provision Y N

US/Canada Coverage Y N

Inside US/Canada – Out-of-Network 60% of \$5,000 80% of \$5,000 90% of \$5,000 Other _____ % of \$

Outside US/Canada & US In-Network 100% Other _____ %

Dental Plan Benefits...

<i>I choose to offer...</i>	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2	<input type="checkbox"/> Option 3	<input type="checkbox"/> Other
Plan Maximum	\$1,000	\$1,000	\$1,500	\$
Deductible (Max 3 per family)	\$100	\$50	\$0	\$
Class A - Preventative	100%	100%	100%	%
Class B - Basic Dental Procedures	80%	80%	80%	%
Class C - Major Dental Procedures	50%	50%	50%	%
Orthodontia (\$2,000 Lifetime)	No coverage	50%	50%	%

Outpatient Prescription Drug Plans...

<i>I choose to offer...</i>	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2	<input type="checkbox"/> Option 3	<input type="checkbox"/> Other
Benefit	Drug card (US only): \$15 Co-pay generic \$30 Co-pay brand name (including mail order)	Usual, Reasonable and Customary charges	50% of Usual, Reasonable and Customary charges	
Subject to Deductible and Coinsurance	No*	Yes	Yes	

*When prescription expenses are incurred in the US or Canada without presenting the card at time of purchase, expenses are subject to Deductible and Coinsurance instead of Co-pay

Additional Options...

- Preventative Package** Benefits are available after 12 months of coverage and are not subject to Deductible
Employees and Dependents age 30 and above: \$250 per Insured Person per Calendar Year
Female Insured Persons age 40 and over (or qualifying Woman at Risk): \$100 per Insured Person per Calendar Year for a screening mammogram
Dependent Children under age 19: up to 3 visits (\$75 maximum per visit) for routine wellness
- Emergency Assistance Package** Emergency Medical Evacuation: for Insured Persons under the age of 65
 Option 1: \$50,000 Lifetime Maximum
 Option 2: \$100,000 Lifetime Maximum
 Option 3: \$150,000 Lifetime Maximum
Emergency Reunion: \$15,000 per Certificate Period
Repatriation of Remains: \$25,000 Maximum per Insured Person
- Mental Health Disorders** \$25,000 Lifetime Maximum after 12 months of continuous coverage, subject to the following sub-limits:
Outpatient Treatment: 50% of a maximum charge of \$100 per visit with a maximum of 52 visits per Calendar Year per Insured Person
Inpatient Treatment: \$10,000 per Calendar Year per Insured Person
- Hospital Indemnity** \$100 per day, seven day maximum (excluding hospitalization for maternity)
- Vision Package** After 12 months of continuous coverage and subject to \$50 Deductible.
 Covered up to \$150 every 24 months for routine eye exam. Covered up to \$100 every 24 months for corrective lenses, contacts or frames

Please tell us about your group's eligibility...

- A. Total number of employees (including US-based & international employees): _____
- B. Total number of eligible employees (International employees only): _____
- C. Does your group presently have domestic and/or international group medical coverage? Y N
 If yes, please attach the following:
 1. Copy of policy or booklet describing your benefits and/or specific plan.
 2. Copy of most recent billing statement.
 3. Copy of most recent claims experience, rates and benefit history for the past three years.
 * The above information is necessary to provide a competitive quote.
- D. Are any eligible employees presently on COBRA? Y N
 If yes, please provide the following information:

Employee: _____	Date / Nature of the Event: _____
Employee: _____	Date / Nature of the Event: _____
Employee: _____	Date / Nature of the Event: _____
- E. Employee Medical Status: Please answer the following questions to the best of your knowledge. For "Yes" answers, provide additional details such as diagnosis, prognosis, treatment (past / current / future) including medication, and degree of recovery.
 1. Has any Employee or Dependent suffered from a condition that resulted in a claim of \$5,000 or more during the last 3 years? Y N
 2. Are any Employees or Dependents currently pregnant? Y N
 3. Are any Employees or Dependents currently hospitalized, confined at home, disabled or incapacitated? Y N
 4. Are any Employees not actively at work performing normal duties due to Illness / Injury? Y N
 5. Are you aware of any circumstances or conditions that could result in an ongoing claim? Y N

