CREWSELECT INTERNATIONAL℠
REQUEST FOR GROUP PROPOSAL

Section 1. Please complete all requested information	
Name of Vessel:	Country of Registry:
Contact Person:	Email Address:
Address:	
Telephone:	Fax:
Please estimate the number of months the vessel will spend outside of U.S. waters in the next 12 months:	
Is vessel owned by a U.S. company? ☐ YES ☐ NO	
Benefit Plans Desired	
Benefit Plan: ☐ Standard ☐ Elite	Currency: ☐ £ ☐ $ ☐ €
Area of Coverage: ☐ Worldwide ☐ Worldwide Excluding the U.S. and Canada ☐ Europe	
Deductible Requested: ☐ Nil ☐ £25/$40/€30 (Elite Only) ☐ £50/$85/€60 ☐ £100/$170/€120 ☐ £250/$425/€295 ☐ £500/$850/€600 ☐ £1,000/$1,700/€1,200 ☐ £2,500/$4,250/€2,950 ☐ £5,000/$8,500/€6,000 ☐ £10,000/$17,000/€11,800	
Life Insurance Benefit: *(minimum $10,000 required for groups of 10 or fewer employees)*	Optional Daily Indemnity: ☐ YES ☐ NO
Does the group presently have medical insurance? ☐ YES ☐ NO If yes, please provide the following information: 1. Copy of present policy and/or booklet describing benefits 2. Copy of most recent billing statement from present carrier 3. Copy of 3 years of most recent claims experience (in most instances, this can be obtained from your present and/or past carrier(s))	
Has another insurance carrier refused your group? ☐ YES ☐ NO	
Total number of crew: #Eligible:	Are all eligible crew members applying? ☐ YES ☐ NO If not, why?

Section 2. Please answer the following questions to the best of your knowledge. If your answer to any question is yes, please give details in the space provided.	
1. To the best of your knowledge, has any employee or dependent suffered from a condition which resulted in a claim of $2,500 or more in the last 3 years?	☐YES ☐NO
2. Are any employees or dependents currently pregnant?	☐YES ☐NO
3. Are any employees or dependents presently hospitalized, confined at home or to a treatment facility, disabled or incapacitated?	☐YES ☐NO
4. Are any employees not actively at work performing his/her normal duties due to illness or injury?	☐YES ☐NO
5. Are you aware of any circumstances, chronic or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims?	☐YES ☐NO
Additional Comments. Attached additional sheets if necessary.	

Section 3. Employee Census. It is important to provide complete census information for each eligible group member. Initial quotation based on census; final rates based on actual enrollment.

Sex	Name	Status*	Date of Birth (day, mo, yr)	Citizenship	Country of Residency

* Status: Employee (E) Spouse (S) Dependent Child (D)

The information provided on this form, including attachments, is intended to provide the company with information necessary to evaluate your group and provide you with premium and coverage indications. Final rates and coverage will be based on the actual enrollment, including evidence of insurability, if applicable. No insurance is in effect unless you are noti ed in writing by the company. Thank you for your interest in CrewSelect International.

Applicant Signature:		Date (day, mo, yr):
Agent Signature:	Date (day, mo, yr):	Agent Number:
Agency:	Address:	
City:	State:	Country:
Phone:	Fax:	Email:

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