

International Medical Group®, Inc.
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GEMSM

Global Educators MedicalSM



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Request for Proposal

School group/Organization Name _____ Contact Person _____
Telephone _____ Fax _____ E-mail _____
Nature of Industry _____
Street Address _____
City _____ State/Province _____ Country _____ Postal Code _____
Requested Effective Date _____
Total number of international assignees (expatriates, third country nationals, key local nationals) _____
Of the international assignee population, total number of U.S. citizens _____
Is the school group/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? _____
Does applicant currently have group medical insurance? Yes No
(If yes, please provide name of carrier, current and 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.)

REQUESTED PLAN OF BENEFITS

Deductible	Max. Deductible	Coverage in the US/Canada	Life Insurance Benefit*
<input type="checkbox"/> \$0	<input type="checkbox"/> 2 per family	<input type="checkbox"/> Include (Std)	<input type="checkbox"/> \$10,000
<input type="checkbox"/> \$100	<input type="checkbox"/> 3 per family (Std)	<input type="checkbox"/> Exclude	<input type="checkbox"/> \$25,000
<input type="checkbox"/> \$250			<input type="checkbox"/> \$50,000
<input type="checkbox"/> \$500	Lifetime Maximum		<input type="checkbox"/> 1 X's Salary to a Maximum* of \$ _____
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,000,000		<input type="checkbox"/> 2 X's Salary to a Maximum* of \$ _____
<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000,000(Std)		<input type="checkbox"/> 3 X's Salary to a Maximum* of \$ _____
<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$ _____		*Maximum available guaranteed issue is \$100,000
<input type="checkbox"/> \$10,000			<input type="checkbox"/> \$ _____
<input type="checkbox"/> \$25,000			
<input type="checkbox"/> _____			

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 of US\$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 actively at work performing his/her normal duties due to illness, injury or other medical/health condition? 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 for any employees or dependents? Yes No

