

# International Marine Medical Insurance<sup>SM</sup>

International Medical Group, Inc.  
Marine Medical Department  
P.O. Box 88509, Indianapolis, IN 46208-0509  
Telephone: 800-628-4664/317-655-4500  
Fax: 317-655-4505



## Request for Group Proposal

Name of Vessel	Country of Registry	Tel	Fax
Contact Person	Address	Email Address	
Please estimate the number of months this vessel will spend outside of U.S. waters in the next 12 months:			
Desired Effective Date (mo/day/yr)			
<b>BENEFIT PLANS DESIRED</b>			
Deductible Requested	<input type="checkbox"/> \$100	<input type="checkbox"/> \$150	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
Life Insurance Benefit	\$25,000 - \$100,000 \$		
Dental Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Is vessel owned by a U.S. company?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please provide the following information:			
Name of parent company			
Address	Telephone	Fax	
City	State	Country	Postal Code
<b>Does group presently have medical insurance?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please attach the following: 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 you present and/or past carrier(s))			
<b>Has another insurance carrier refused your group?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Total number of crew</b> _____	<b>Are all crew members applying?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not, why? _____		
<b>Are any employees presently on COBRA?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
(If yes, list those employees and list date COBRA began and qualifying event. Attach additional sheets if necessary.)			
Employee			
Employee			
Employee			
Employee			
Employee			

