

# 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			

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 during the last 3 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are any employees or dependents currently pregnant?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are any employees or dependents presently hospitalized, confined at home or to a treatment facility, disabled or incapacitated?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Are any employees not actively at work performing his/her normal duties due to illness or injury?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Are you aware of any circumstances, chronic or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Additional Comments:** (Attach additional sheets if necessary)

---

---

---

---

---

---

---

**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	Citizenship

\*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 notified in writing by the company. Thank you for your interest in **International Marine Medical Insurance<sup>SM</sup>**.

Applicant Signature \_\_\_\_\_ Date (mo/day/yr) \_\_\_\_\_

Agent Signature \_\_\_\_\_ Date \_\_\_\_\_ Agent Number \_\_\_\_\_

Agency \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_