MP+ International Request for Proposal



PART 1.										
Participating Organization Name:	А	Authorized Representative Contact:								
Telephone:	Fax:	E	mail:							
Street Address:						City:				
State/Province:	Country:	Р	Postal/Zip Code:				Requested Effective Date: (Day, Mo., Yr.)			
Nature of Business:		T	ype of Work	Employees	Perform:					
Total Number of International Employees:	Total Number of Eligible International Employees	s: Ir	otal Number ncluded in th mployee Co	Total Number of Local Nationals Applying:						
Is the company/organization a subsidiary or division of a U.S. or Canadian corporation? If Yes, U.S. or Canadian?							Yes		No	
Are any employees/dependents currently residing in the U.S. or Canada? If Yes, please provide details in census section.							Yes		No	
Do you expect the number of employees to vary in the next 12 months? If Yes, please provide details.							Yes		No	
How many covered employees and appointed representatives have been employed for less than 6 months?							Yes		No	
Does the company currently have or offer medical insurance? If Yes, please provide name of carrier, current and renewal rates, schedule of benefits, and claims experience.							Yes		No	
Has another insurance company refused to quote, terminated, or declined to offer coverage to the organization or its participants? If Yes, please provide details.							Yes		No	
Are any employees or dependents presently covered under COBRA or other continuation plans? If Yes, please indicate those individuals in the census.							Yes		No	
If local nationals are applying for coverage, will the employees be travelling outside of their country of residence? If Yes, how often? For how long?							Yes		No	
PART 2. REQUESTED PLAN BENEFIT	S									
Non-U.S. Deductible: ☐ \$0 ☐ \$100	\$250 \$500	\$750	\$1,000	\$2,500	□ \$5,000	\$10,000	☐ Other:	\$		
U.S. Deductible: \$0 \$100	\$250 🗆 \$500 🗆	\$750	\$1,000	\$2,500	\$5,000	□ \$10,000	☐ Other:	\$		
Coverage Plan:	☐ Alternative		Maximum	Deductible:	2 per Fa	amily	☐ 3 per l	Fam	ily	
Coverage Area (Choose One):										
Additional Benefits Upon Request: Platinum USA Benefit Rider Creditable Coverage Offset Dental Other: Guarantee Issue for New Employees										
Lifetime Maximum: ☐ \$1,000,000 ☐ \$5,000,000 ☐ \$8,000,000 ☐ Other: \$										
Life Insurance Benefit: \$10,000 \$25,000 \$50,000 \$1 x Salary to maximum of \$ 2 x Salary to maximum of \$ Other \$										
Implementation needs: Reporting	9									
☐ Enrollment										

For organizations with 2-24 employees:

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	Please answer the f		uestions. If yo	ur answer t	o any question i	s Yes, please	give details in	the spa	ce pro	vided.												
Has any employee or dependent suffered from an injury, illness or other medical/health condition that resulted in total claims, expenses, or costs of \$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 able to work or perform activities of daily living due to illness, injury or other medical/health condition?									Yes		No											
5. Are you aware of any circumstances, chronic, congenital, terminal, pre-existing, or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims, expenses, or costs for any employees or dependents?									Yes		No											
PART 4.	PART 4. CENSUS LISTING (For groups of less than 100 employees)																					
Gender	Employee Name	Class*	Coverage Needed**	Date of Birth or Age	Occupation	Annual Salary***	# of Dependents Residing in U.S. or Canada	g Citizenship r		Country of Assignment												
	a category of employees with							mpt, non-e	exempt, or	sales)												
	ployee only (E) Employee+		· ·			additional pages as	s necessary)															
	lary only if a proposal is desir CERTIFICATION	ea for life irisurari	ce coverage basea u	роп а типпріє от	salary																	
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Authorized Representative Contact:					Title:	Title:																
Producer Name: SHIRAZI BENEFITS				Agency N	Agency Name:																	
Are You t	he Producer of Recor	rd? 🔲 Ye	s 🔲 N	0																		
Producer Signature:				Date (Day,	Date (Day, Mo., Yr.):																	
IMG Producer Number (if contracted with IMG): 80001791				Email: † ŗ	Email: tmiller@shirazibenefits.com																	
Telephone: 970-356-5151					Fax: 970-356-5154																	