Special Group Travel Request for Proposal

To be completed by producer

INTERNATIONAL MEDICAL GROUP

DEMOGRAPHIC INFORMATION			
Sponsoring Organization:			
Describe Organization:			
Number of Proposed Insureds:		Average Age of Proposed Insureds:	
Citizenship *(Percent or Number)*: U.S.:	Non-U.S.:		
Requested Effective Date *(MM,DD,YY)*:		Length of Coverage:	
Destinations:			
How Long Has Coverage Been in Force *(If applicable)*:		Reason for Change in Carrier *(If applicable)*:	
Competitors Quoting *(If known)*:			

COVERAGE INFORMATION - *Please attach information if available*					
Current Coverage: ❑ Yes *(Carrier Name):* ❑ No				Copy of Current Plan Design: ❑ Yes ❑ No	
Rate History with Enrollment Numbers: ❑ Yes ❑ No *(Preferably last three years)*				Loss Ratio/Claims Information: ❑ Yes ❑ No *(Preferably last three years)*	
Proposed Group Plan: ❑ Patriot Travel ❑ Patriot Exchange ❑ Student Health Advantage ❑ Patriot Green ❑ Patriot Platinum ❑ Patriot Multi-Trip ❑ Sky Rescue					
Maximum Benefit Amount(s): $	$	$		Type: ❑ Lifetime ❑ Per Illness/Injury	
Deductible(s) Amount: $	$	$		Type: ❑ Calendar Year ❑ Per Illness/Injury ❑ Per Period	
Coinsurance Amount(s): ❑ 80/20	❑ 90/10	❑ 100/0	❑ Other	Maximum out-of-pocket:	
Rate Mode: ❑ Annual	❑ Monthly	❑ Daily		Type: ❑ Composite ❑ Age-banded	
Payment Method: ❑ Event	❑ Monthly			Optional Riders/Coverage(s):	

PRODUCER INFORMATION		
Producer Name:	Producer Number:	Parent Number *(If applicable)*:
Are You the Current Agent of Record: ❑ Yes ❑ No *(Relationship to group)*:	Current Commission: %	Date of Request *(MM, DD, YY)*:
Notes:		

HOME OFFICE USE ONLY	
Date RFP was Received *(MM, DD, YY)*:	Account Executive:
Date Sent to Underwriting *(MM, DD, YY)*:	Manager Approval:

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