



# GlobalSelect® Group International Healthcare Cover

## Request for MHD Group Quotation

IMG Europe Limited  
36-38 Church Road, Burgess Hill,  
West Sussex, RH15 9AE,  
United Kingdom  
Tel : +44 (0) 1444 46 55 55  
Fax : +44 (0) 1444 46 55 50  
e-mail : info@imgeurope.co.uk

In order for IMG Europe to provide an indication of premium for a group, please complete this form and send to IMG Europe.

Completed By :  Group  Broker  IMG Europe

1. Details Of Group/Organisation			
Group/Organisation Name	Nature of Industry/Business	Requested Effective Date	Contact Person
Telephone	Fax	E-Mail	Website
Address			Country
Intermediary/Broker Details			
Intermediary Name :	IMG/E Intermediary Number	Are You the Broker of Record	Yes /No

2. About the group to be Insured			
Total number of international staff/dependents to be insured (i.e. expatriates, third country nationals, key local nationals)? Staff Members: ____ + Dependents: ____ = ____ Total Lives			
Has any Insurance company refused to quote on this group?	Not sure	Preferred Quote/Plan Currency	GBP£ / US\$ / Euro€
Does the group currently have medical insurance Yes / No			
<i>If yes, please provide details of insurer, current and renewal rates, schedule of benefits and claims experience.</i>			
Insurer	Current rate (Required for MHD)	£ / \$ / € _____	
Plan Attached (Schedule of benefits required for MHD) Yes / No	Renewal Rate Offered (Required for MHD)	£ / \$ / € _____	
Claims Experience (3 years) Available / Not Available	Best Rate Offered (like terms)	£ / \$ / € _____	
If Not Available : 3 years census / total premium paid details			
Please include any special conditions of current cover e.g. Exclusions/Endorsements, CPME or special deductibles not listed in the Schedule of Benefits.			
Employer contribution _____%	Number of Employees to be covered _____		
Number of Eligible Employees _____	Number of Employees to be covered who are local nationals _____		

3. Basis of Group Transfer Application		Tick as appropriate
Group Transfer Provisions are only available to groups currently insured with a different medical insurance provider's plan that would like to apply to transfer to GlobalSelect. (Applies only to employees/dependents who are covered under prior plan immediately preceding the effective date of this cover.)		
Underwriting Basis <small>(Refer to IMG Europe for definitions)</small>	<input type="checkbox"/> Medical History Disregarded (MHD) must meet eligibility provisions – refer to MHD Checklist for further details	
	Name of Prior Carrier: _____	

3. Requested Cover Details – Applicable to all group members		
- if cover details for any members/sub groups will be different - please identify individual's area/level of cover and excess on census		
3.1 Select the Geographical Area Of Cover (Tick one)	<input type="checkbox"/> Area 1 : Europe	
	<input type="checkbox"/> Area 2 : Worldwide excluding the USA, Canada, China, Hong Kong, Macau, Japan, Singapore and Taiwan	
	<input type="checkbox"/> Area 3 : Worldwide	
	<input type="checkbox"/> Other - Custom Area : _____	
<input type="checkbox"/> Mixed (10+ Employees) : Refer to Census		
Questions relating to US citizens and Cover in the USA:		
How many individuals reside in the USA or Canada?	How many U.S. citizens are in the group?	How many U.S. citizens in the group reside in the USA?

3.2 Select Which Plan(s) and Level(s) Of Excess you would like quotes for			
<input type="checkbox"/> Mixed (10+ Employees) : Refer to Census			
HeadStart Plan	Basic Plan	Standard Plan	Executive Plan
£100/\$180/€150 – Standard Excess	£100/\$180/€150 – Standard Excess	£50/\$90/€75 – Standard Excess	£25/\$45/€38 – Standard Excess
OR... Voluntary Medical Excess Options: The voluntary excess options do not apply to the optional add-ons plans or to non-medical sections of cover.			
N/A	N/A	Nil Excess	Nil Excess
N/A	N/A	N/A	£50/\$90/€75 Excess
N/A	N/A	£100/\$180/€150 Excess	£100/\$180/€150 Excess
£250/\$450/€375	£250/\$450/€375	£250/\$450/€375	£250/\$450/€375
£500/\$900/€750	£500/\$900/€750	£500/\$900/€750	£500/\$900/€750
£1,000/\$1,800/€1,500	£1,000/\$1,800/€1,500	£1,000/\$1,800/€1,500	£1,000/\$1,800/€1,500
£2,500/\$4,500/€3,750	£2,500/\$4,500/€3,750	£2,500/\$4,500/€3,750	£2,500/\$4,500/€3,750
£5,000/\$9,000/€7,500	£5,000/\$9,000/€7,500	£5,000/\$9,000/€7,500	£5,000/\$9,000/€7,500
£10,000/\$18,000/€15,000	£10,000/\$18,000/€15,000	£10,000/\$18,000/€15,000	£10,000/\$18,000/€15,000

4. Optional Covers – Applicable to all group members		*Delete as appropriate
Do you require quotes for Global Personal Accident Plan and/or Global Daily Indemnity – Hospital income Plan?	No, 1 or 2 unit(s)*	Global Personal Accident Plan
	No / Yes*	Global Daily Indemnity – Hospital Income Plan



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**Claims Disclosure Statement**

**The Employer is required to disclose in respect of all persons (Employees and Dependents) to be covered by this Plan.** If the answer to any of the following questions is yes, please give details in the space provided. Attach additional pages as necessary. Final rates and cover will be based upon the actual enrolment, including previous provider's cover/terms. Questions must be answered by Company Secretary or equivalent officer.

1. Is any person to be covered under this Plan currently pregnant? If yes, please provide complete details  Yes  No

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2. Participants (employee or dependent) who are or are expected to be absent from work due to work related or non-work related disability on the effective date of coverage.  Yes  No

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3. Participants (employee or dependent) who are or have been pre-authorized or confined to a hospital or medical facility prior to the date of completion of this Statement, or who are suffering from a medical condition whereby they are planning or likely to result in a need for an in-patient hospital stay.  Yes  No

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4. Participants with a history or a current diagnosis or incurred any claims in the past 12 months for Cancer or HIV/AIDS.  Yes  No

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5. Participants currently on a waiting list or contemplating any type of Transplant.  Yes  No

**If the answer to any of the above is YES, please give full details below. Attach additional sheet if necessary.**

**5. Group Member Details**

Please list each person to be covered under this Policy (you may attach a schedule/census if this is more convenient): **Tick if census attached**   
**Alternatively for group of 100+ lives, you may complete the Census Summary below. - Please include the info below**

Name	Sex	Date of Birth	Nationality	Country of Residence	Insured Type* EE / S / D / SP

**\*Insured Type Key :** Employee (EE), Spouse (S), Dependent Child - Under 23 if in full time education (D), Single Parent/Employee (SP) and list all D's

**Census Summary – For Group of 100+ lives :** Please indicate the number of each Insured units **Tick if census attached**   
**: NOT required if a full census has been provided containing Name, Sex, Age/Date of Birth, Nationality, Country of Residence and Insured Type**  
 i.e. an Employee and Spouse would be ONE "EE+Spouse" unit, and Employee with Spouse and children would be ONE "EE+ Spouse+Children" unit,  
 EE Only + Child(ren) refers to one parent families or where no cover is required for the spouse, but is required for the employee and their children.

Age	MALE Employee				FEMALE Employee			
	Employee (EE)	EE + Spouse	EE + Spouse +Child(ren)	EE Only +Child(ren)	Employee (EE)	EE + Spouse	EE + Spouse + Child(ren)	EE Only + Child(ren)
18-24								
25-29								
30-34								
35-39								
40-44								
45-49								
50-54								
55-59								
60-64								
65-69								
70+								

As representative for the Group named above, I hereby declare to the best of my knowledge that the information, including any attachments provided, is complete, true and accurate. I agree this information will constitute part of the company's application and be the basis upon which IMG Europe Ltd. provide premium and cover indications. I understand that failure to disclose any material facts may result in the contract being void. (If you are any doubt whether certain facts are material, these should be disclosed).

**Signed :** \_\_\_\_\_ **Dated :** \_\_\_\_\_

**Name :** \_\_\_\_\_ **Title :** \_\_\_\_\_  
 (This form must be completed and signed by the Company Secretary or equivalent officer for and on behalf of all Members/Applicants)