**International Marine Medical Insurance**SM
**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)

**BENEFIT PLANS DESIRED**

Deductible Requested ☐ $100 ☐ $150 ☐ $250 ☐ $500 ☐ $1,000

Life Insurance Benefit $25,000 - $100,000 $

Dental Benefit ☐ Yes ☐ No

**Is vessel owned by a U.S. company?** ☐ Yes ☐ No
If yes, please provide the following information:

Name of parent company

Address Telephone Fax

City State Country Postal Code

**Does group presently have medical insurance?** ☐ Yes ☐ 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))**

**Has another insurance carrier refused your group?** ☐ Yes ☐ No

**Total number of crew**_____ **Are all crew members applying?** ☐ Yes ☐ No

If not, why? _____

**Are any employees presently on COBRA?** ☐ Yes ☐ No
(If yes, list those employees and list date COBRA began and qualifying event. Attach additional sheets if necessary.)

Employee

Employee

Employee

Employee

Employee

Updated 04/17

**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? ☐ Yes ☐ No
2. Are any employees or dependents currently pregnant? ☐ Yes ☐ No
3. Are any employees or dependents presently hospitalized, confined at home or to a treatment facility, disabled or incapacitated? ☐ Yes ☐ No
4. Are any employees not actively at work performing his/her normal duties due to illness or injury? ☐ Yes ☐ No
5. Are you aware of any circumstances, chronic or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims? ☐ Yes ☐ 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℠**.

Applicant Signature_____ Date (mo/day/yr) _____

Agent Signature_____ Date_____ Agent Number_____

Agency_____ Address_____

City_____ State_____ Country_____

Phone_____ Fax_____ Email_____