

International Marine Medical InsuranceSM

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	<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	
Is vessel owned by a U.S. company?	<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
Does group presently have medical insurance? <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))			
Has another insurance carrier refused your group? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Total number of crew _____		Are all crew members applying? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, why? _____			
Are any employees presently on COBRA? <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?
2. Are any employees or dependents currently pregnant?
3. Are any employees or dependents presently hospitalized, confined at home or to a treatment facility, disabled or incapacitated?
4. Are any employees not actively at work performing his/her normal duties due to illness or injury?
5. Are you aware of any circumstances, chronic or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims?

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.

Table with 5 columns: Sex, Name, Status*, Date of Birth, Citizenship. Multiple empty rows for data entry.

*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.

Applicant Signature _____ Date (mo/day/yr) _____
Agent Signature _____ Date _____ Agent Number _____
Agency _____ Address _____
City _____ State _____ Country _____
Phone _____ Fax _____ Email _____