

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. | | | |
| <i>(In most instances, this can be obtained from you present and/or past carrier(s))</i> | | | |
| 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 | | | |
| <i>(If yes, list those employees and list date COBRA began and qualifying event. Attach additional sheets if necessary.)</i> | | | |
| Employee | | | |
| Employee | | | |
| Employee | | | |
| Employee | | | |
| Employee | | | |

