

PART 1.

Participating Organization Name:		Authorized Representative Contact:	
Telephone:	Fax:	Email:	
Street Address:			City:
State/Province:	Country:	Postal/Zip Code:	Requested Effective Date: <i>(Day, Mo., Yr.)</i>
Nature of Business:		Type of Work Employees Perform:	
Total Number of International Employees:	Total Number of Eligible International Employees:	Total Number of U.S. Citizens Included in the International Employee Count:	Total Number of Local Nationals Applying:
Is the company/organization a subsidiary or division of a U.S. or Canadian corporation? If Yes, U.S. or Canadian?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any employees/dependents currently residing in the U.S. or Canada? If Yes, please provide details in census section.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you expect the number of employees to vary in the next 12 months? If Yes, please provide details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any covered employees and appointed representatives been employed for less than 6 months? If yes, how many? _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the company currently have or offer medical insurance? If Yes, please provide name of carrier, current and renewal rates, schedule of benefits, and claims experience.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has another insurance company refused to quote, terminated, or declined to offer coverage to the organization or its participants? If Yes, please provide details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any employees or dependents presently covered under COBRA or other continuation plans? If Yes, please indicate those individuals in the census.			<input type="checkbox"/> Yes <input type="checkbox"/> No
If local nationals are applying for coverage, will the employees be travelling outside of their country of residence? If Yes, how often? For how long?			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART 2. REQUESTED PLAN BENEFITS

Non-U.S. Deductible:	<input type="checkbox"/> \$0	<input type="checkbox"/> \$100	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500	<input type="checkbox"/> \$750	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> Other: \$ _____
U.S. Deductible:	<input type="checkbox"/> \$0	<input type="checkbox"/> \$100	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500	<input type="checkbox"/> \$750	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> Other: \$ _____
Coverage Plan:	<input type="checkbox"/> Standard	<input type="checkbox"/> Alternative	Maximum Deductible:		<input type="checkbox"/> 2 per Family	<input type="checkbox"/> 3 per Family				
Coverage Area <i>(Choose One)</i> :	<input type="checkbox"/> Worldwide <input type="checkbox"/> Custom – Please indicate countries covered: _____ <input type="checkbox"/> Worldwide Excluding* the U.S., Canada, China, Hong Kong, Japan, Macau, Singapore and Taiwan <small>*Except 30 days emergency/accident</small>									
Additional Benefits Upon Request:	<input type="checkbox"/> Platinum USA Benefit Rider <input type="checkbox"/> Creditable Coverage Offset <input type="checkbox"/> Dental 1 <input type="checkbox"/> Dental 2 <input type="checkbox"/> Dental 3		<input type="checkbox"/> Other: _____ <input type="checkbox"/> Guarantee Issue for New Employees		<input type="checkbox"/> Daily Hospital Indemnity <input type="checkbox"/> AD&D					
Lifetime Maximum:	<input type="checkbox"/> \$1,000,000	<input type="checkbox"/> \$5,000,000	<input type="checkbox"/> \$8,000,000	<input type="checkbox"/> Other: \$ _____						
Life Insurance Benefit: (Optional)	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> 1 x Salary to maximum of \$ _____ <input type="checkbox"/> 2 x Salary to maximum of \$ _____ <input type="checkbox"/> 3 x Salary to maximum of \$ _____ <input type="checkbox"/> Other \$ _____									
Implementation needs:	<input type="checkbox"/> Reporting _____ <input type="checkbox"/> Enrollment _____									

PART 3. REQUESTED SERVICES (ADDITIONAL ASSISTANCE SERVICES UPON REQUEST)

Medical Security Evacuation Services
 Travel Intelligence Portal
 Remote Mental Health Services
 Teleconsultation

