MP+International





PART 1.											
Participating Organization Name: Authorized Repres					ve Contact:						
Telephone:	Fax:		Email:								
Street Address:						City:					
State/Province:	Country:		Postal/Zip Co	Requested Effective Date: (Day, Mo., Yr.)							
Nature of Business:			Type of Work	Employees	Perform:						
Total Number of International Employees:	Total Number of Eligible International Employee	es:	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?							Yes		No		
Are any employees/dependents currently residing in the U.S. or Canada? If Yes, please provide details in census section.							Yes		No		
Do you expect the number of employees to vary in the next 12 months? If Yes, please provide details.							Yes		No		
Have any covered employees and appointed representatives been employed for less than 6 months? If yes, how many?							Yes		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.							Yes		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.							Yes		No		
Are any employees or dependents presently covered under COBRA or other continuation plans? If Yes, please indicate those individuals in the census.							Yes		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?							Yes		No		
PART 2. REQUESTED PLAN BENEFIT	S										
Non-U.S. Deductible: \$0 \$100	\$250 \$500	\$750	1 \$1,000	\$2,500	\$5,000	\$10,000	O Coth	ner: \$			
U.S. Deductible:	Deductible: \$\bigsim \\$0 \bigsim \\$100 \bigsim \\$250 \bigsim \\$500 \bigsim \\$750 \bigsim \\$1,000 \bigsim \\$2,500 \bigsim \\$5,000 \bigsim \\$10,000 \bigsim \\$0 ther: \$\bigsim \bigsim \\$1,000 \bigsim \\$2,500 \bigsim \\$2,500 \bigsim \\$5,000 \bigsim \\$10,000 \bigsim										
Coverage Plan: Standard Alternative Maximum Deductible: 2 per Family 3 per Family							ily				
Coverage Area (Choose One): Ustom – Please indicate countries covered: Worldwide Excluding* the U.S., Canada, China, Hong Kong, Japan, Macau, Singapore and Taiwan *Except 30 days emergency/accident*											
Additional Benefits Upon Request: Platinum USA Benefit Rider Other: Daily Hospital Indemnity Guarantee Issue for New Employees AD&D Dental 1 Dental 2 Dental 3											
Lifetime Maximum: ☐ \$1,000,000 ☐ \$5,000,000 ☐ \$8,000,000 ☐ Other: \$											
Life Insurance Benefit: \$\Bigcup \\$10,000 \Bigcup \\$25,000 \Bigcup \\$50,000 \Bigcup \\$1 x Salary to maximum of \\$											
Implementation needs:											
■ Enrollment											
PART 3. REQUESTED SERVICES (ADDITONAL ASSISTANCE SERVICES UPON REQUEST)											
☐ Medical Security Evacuation Se	rvices Travel Intellig	gence F	Portal 🗖 F	Remote Men	ntal Health S	Services	☐ Teled	onsult	ation		

For organizations with 2-24 employees:

PART 4. Please answer the following questions. If your answer to any question is Yes, please give details in the space provided. Attach additional pages as necessary.													
 Has any employee or dependent suffered from an injury, illness or other medical/health condition that resulted in total claims, expenses, or costs of \$2,500 or more during the last three years? 								d		Yes		No	
 Are any employees or dependents currently hospitalized, confined at home or a treatment facility, disabled or incapacitated? 										Yes		No	
Are any employees or dependents currently pregnant?										Yes		No	
4. Are any employees or dependents not able to work or perform activities of daily living due to illness, injury or other medical/health condition?										Yes		No	
 Are you aware of any circumstances, chronic, congenital, terminal, pre-existing, or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims, expenses, or costs for any employees or dependents? 										Yes		No	
PART 5. C	ENSUS LISTING (F	or groups o	f less than 100) employee:	s)								
Gender	Employee Name	Class*	Coverage Needed**	Date of Birth (MM/DD/YYYY)	Occupation	Annual Salary***	# of Dependents Residing in U.S. or Canada	Citizenship		nip	Country of Assignment		
*Defined as a category of employees with easily distinguishable and identifiable common characteristics (i.e. management, non-management, hourly, salary, exempt, non-exempt, or sales)													
**Status: Emp	oloyee only (E) Employee+	Spouse (ES) Em	nployee+ Child(ren) (i	EC) Employee+	Family (EF) (attach ad	dditional pages as	necessary)						
	ary only if a proposal is desire	ed for life insuran	ce coverage based up	oon a multiple of :	salary								
	CERTIFICATION					6.1							
International Medical Group®, Inc., is authorized representative, and plan administrator of the insurance contract which may be issued by the insurance carrier. IMG or the insurance carrier may ask for more information, depending on the request, responses, and information later revealed. The undersigned plan administrator and/or authorized representative of the plan certifies all information shown on this form is correct and complete to the best of his or her knowledge and belief. It is understood IMG and the insurance carrier intend to rely on this information as part of the premium and coverage evaluation process. It is also understood if the information provided is not accurate, truthful, correct, and complete, IMG and the insurance carrier reserve the right to decline coverage, terminate coverage or revise premium rates accordingly. The plan and the undersigned acknowledge, understand, and agree 1) coverage is only offered to eligible participants whose applications are approved in writing by IMG and following timely receipt of premium owed and 2) this document is merely an invitation to inquire, not an application, and not a description of any losses for which benefits are payable.													
Authorized Representative Contact:					Title:	Title:							
Producer Name: Ken Tolchin				Agency N	Agency Name:								
Are You the Producer of Record? Yes No													
Producer Signature:					Date (Day,	Date (Day, Mo., Yr.):							
IMG Producer Number (if contracted with IMG): 536537				Email: k (Email: ken@practicalinsurancesolutions.com								
Telephone: 561-212-8092				Fax: 56	Fax: 561-883-2150								

Send by one of the following secure methods: Secure Message Center: www.imglobal.com/secure-message-center-encrypted Email: insurance@imglobal.com

Fax: +1.317.655.4505 For other inquiries call: +1.317.655.4500