## **MP+International**





PART 1.										
Participating Organization Name: Authorized Representative C					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 Numbe Included in t Employee Co	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	<b>1</b> \$1,000	<b>\$2,500</b>	\$5,000	\$10,000	O Coth	ner: \$		
U.S. Deductible:	□ \$0 □ \$100 □ \$250 □ \$500 □ \$750 □ \$1,000 □ \$2,500 □\$5,000 □\$10,000 □Other: \$									
Coverage Plan: Standard Alternative Maximum Deductible: 2 per Family 3 per Famil							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.													
<ol> <li>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?</li> </ol>								d		Yes		No	
<ol> <li>Are any employees or dependents currently hospitalized, confined at home or a treatment facility, disabled or incapacitated?</li> </ol>										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		
5. Are you aware of any circumstances, chronic, congenital, terminal, pre-existing, or continuing medical, mental or											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: Employee only (E) Employee+ Spouse (ES) Employee+ Child(ren) (EC) Employee+ Family (EF) (attach additional pages as necessary)										-			
***Provide sal	ary only if a proposal is desire	ed for life insuran	ce coverage based u	oon a multiple of	salary								
	CERTIFICATION												
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: IWB Benefits				Agency N	Agency Name:								
Are You the Producer of Record?													
Producer Signature:					Date (Day,	Date (Day, Mo., Yr.):							
IMG Producer Number (if contracted with IMG): 539861				Email: <b>ir</b>	Email: insuredwithbenny@gmail.com								
Telephone: 3039468992				Fax: 72	Fax: 7206740771								

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

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