## **MP+International** Request for Proposal



PART 1.											
Participating Organization Name:		Authorized Representative Contact:									
Telephone:	Fax:	Email:									
Street Address:	City:										
State/Province:	Country:	Postal/Zip Code:	Requested Effective Date: (Day, Mo., Yr.)								
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 subsidian U.S. or Canadian?	🗖 Yes 🗖 No										
Are any employees/dependents current census section.	🗋 Yes 🔲 No										
Do you expect the number of employee	🗖 Yes 🗖 No										
Have any covered employees and appo	Yes No										
Does the company currently have or off current and renewal rates, schedule of b	🗖 Yes 🗖 No										
Has another insurance company refused organization or its participants? If Yes, p	🗖 Yes 🗖 No										
Are any employees or dependents prese please indicate those individuals in the	Yes No										
If local nationals are applying for covera residence? If Yes, how often? For how le	🗖 Yes 🗖 No										
PART 2. REQUESTED PLAN BENEFITS											
Non-U.S. Deductible: 🔲 \$0 🔲 \$100	\$250 \$500 \$75	0 🖸 \$1,000 🔲 \$2,500 🗖 \$5,000	□\$10,000 □Other: \$								
J.S. Deductible: \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$											
Coverage Plan: Standard Alternative Maximum Deductible: 2 per Family 3 per Family											
Coverage Area (Choose One): Worldwide Custom – 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         Creditable Coverage Offset       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:       \$10,000       \$25,000       \$1 x Salary to maximum of \$         (Optional)       \$2 x Salary to maximum of \$       \$3 x Salary to maximum of \$         Other \$       \$3 x Salary to maximum of \$											
Implementation needs:  Reporting											
Enrollment											
PART 3. REQUESTED SERVICES (ADDITONAL ASSISTANCE SERVICES UPON REQUEST)											
🗖 Medical Security Evacuation Services 🛛 Travel Intelligence Portal 🔲 Remote Mental Health Services 🔲 Teleconsultation											

## 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	<b>D</b> Y	'es		No
<ol> <li>Are any employees or dependents currently hospitalized, confined at home or a treatment facility, disabled or incapacitated?</li> </ol>								<b>D</b> Y	'es		No	
3. Are any employees or dependents currently pregnant?									<b>D</b> Y	'es		No
<ol> <li>Are any employees or dependents not able to work or perform activities of daily living due to illness, injury or other medical/health condition?</li> </ol>								<b>D</b> Y	'es		No	
<ol> <li>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?</li> </ol>									D Y	'es		No
	CENSUS LISTING (F	or aroups a	f less than 10	0 emplovee	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 Country Assignm				
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										_		
										_		
*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 salary only if a proposal is desired for life insurance coverage based upon a multiple of salary												
PART 6.	CERTIFICATION	•					·	•				
International Medical Group <sup>®</sup> , 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: KS WEYAND INC DBA COLORADO INS PROS 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): 541489				Email: S	Email: stacey@coip.us							
Telephone: 303-349-5092					Fax:							