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



PART 1.							
Participating Organization Name:		Authorized Representative Contact:					
Telephone:	Fax:	Email:					
Street Address:	City:						
State/Province:	/Province: Country: Postal/Zip Code:						
Nature of Business:	Nature of Business: Type of Work Employees Perform:						
Total Number of International Employees:	Total Number of Eligible International Employees:	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	5						
Non-U.S. Deductible: 🔲 \$0 🔲 \$100	\$250 \$500 \$75	0 🖸 \$1,000 🔲 \$2,500 🗖 \$5,000	□\$10,000 □Other: \$				
U.S. Deductible:  \$0 \$ \$100	.S. Deductible: \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$ \$\$						
Coverage Plan:       Image: Standard       Image: Alternative       Maximum Deductible:       2 per Family       Image: Standard       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							
	latinum USA Benefit Rider reditable Coverage Offset ental 1 Dental 2 Dent	Other: Guarantee Issue for New Emp tal 3					
Lifetime Maximum: 🔲 \$1,000,000	\$5,000,000	00 🔲 Other: \$					
Life Insurance Benefit:       \$10,000       \$25,000       \$50,000       \$1 x Salary to maximum of \$         (Optional)       \$2 x Salary to maximum of \$       \$3 x Salary to maximum of \$         Other \$       Other \$							
Implementation needs:  Reporting							
Enrollment							
PART 3. REQUESTED SERVICES (ADD	DITONAL ASSISTANCE SERVI	ICES UPON REQUEST)					
Medical Security Evacuation Security	rvices 🛛 🗖 Travel Intelligence	Portal 🛛 🗖 Remote Mental Health S	Services				

## For organizations with 2-24 employees:

	ase answer the fo tional pages as n		estions. If yo	ur answer to	o any question i	s Yes, please	give details in t	the s	pace	pro	vided.	
								No				
									Yes		No	
3. Are any	employees or dep	endents cu	rrently pregna	nt?						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 nervous conditions which can be expected to produce ongoing claims, expenses, or costs for any employees or dependents?							Yes		No			
PART 5. CEN	NSUS LISTING (Fo	or groups of	f less than 100	) employees	s)							
Gender E	mployee Name	Class*	Coverage Needed**	Date of Birth (MM/DD/YYYY)	Occupation	Annual Salary***	# of Dependents Residing in U.S. or Canada	Citi	Citizenship Country of Assignme		-	
*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 F	Authorized Representative Contact: Title:											
Producer Name: Aaron L Grober Agency Agency Name:												
Are You the Producer of Record?  Yes No												

Producer Signature:	Date (Day, Mo., Yr.):
IMG Producer Number (if contracted with IMG): $59077$	Email: jwildstein@giains.com
Telephone: 516-872-9500 Ext:3027	Fax: 516-872-1077

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