International Marine Medical Insurance
Request for Proposal

PART 1.			
Name of Vessel:		Person Contact:	
Telephone:	Fax:	Email:	
Address:			City:
State/Province:	Country of Registry:	Postal/Zip Code:	Requested Effective Date *(Day, Mo., Yr.)*:
Total Number of Crew:		Total Number of Crew Applying:	
Please estimate the number of months this vessel will spend outside of U.S. waters in the next 12 months:			

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
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?	☐ Yes ☐ No

PART 2. REQUESTED PLAN BENEFITS

Deductible: ☐ $100 ☐ $150 ☐ $250 ☐ $500 ☐ $750 ☐ $1,000

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*

Life Insurance Benefit*: ☐ $10,000 ☐ $25,000 ☐ other ($100,000 maximum)_____

** (2-10 lives, $10,000 minimum required). Maximum available guaranteed issue is $100,000.*

Dental Benefit: ☐ Yes ☐ No

PART 3. Please answer the following questions. If your answer to any question is Yes, please give details in the space provided. Attached additional pages as necessary.	
1. 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?	☐ Yes ☐ No
2. Are any employees or dependents currently hospitalized, confined at home or a treatment facility, disabled or incapacitated?	☐ Yes ☐ No
3. 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 nervous conditions which can be expected to produce ongoing claims, expenses, or costs for any employees or dependents?	☐ Yes ☐ No

PART 4. CENSUS SUMMARY (Required for groups of 100 lives or more)

AGE	MALE				FEMALE			
	Employee	Employee+ Spouse	Employee+ Child(ren)	Employee+ Family	Employee	Employee+ Spouse	Employee+ Child(ren)	Employee+ Family
19-24								
25-29								
30-34								
35-39								
40-44								
45-49								
50-54								
55-59								
60-64								
65-69								
70+								

CENSUS LISITING (For groups of less than 100 employees)

Gender	Employee Name	Class***	Coverage Needed*	Date of Birth *(Day, Mo., Yr.)* or Age	Occupation	Annual Salary**	# of Dependents Residing in U.S. or Canada	Nationality	Country of Assignment

**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*

****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)*

PART 5. 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:
Producer Name: Derek Patterson	Agency Name: EGLOBALHEALTH INSURERS AGENCY, LLC.
Are You the Producer of Record? ☐ Yes ☐ No	
Producer Signature:	Date *(Day, Mo., Yr.)*:
IMG Producer Number (if contracted with IMG): 186448	Email: info@eglobalhealth.com
Telephone: 417-882-1413	Fax: