International Marine Medical InsuranceSM International Medical Group, Inc.

International Medical Group, Inc. Marine Medical Department P.O. Box 88509, Indianapolis, IN 46208-0509 Telephone: 800-628-4664/317-655-4500 Fax: 317-655-4505



Request for Group Proposal

Name of Vessel Country of Registry	Tel Fax				
Contact Person Address		Email Address			
Please estimate the number of months this vessel will spend outside of U.S. waters in the next 12 months:					
Desired Effective Date (mo/day/yr)					
BENEFIT PLANS DESIRED					
Deductible Requested		500 🗆 \$1,000			
	\$				
Dental Benefit					
Is vessel owned by a U.S. company? □ Yes □ If yes, please provide the following information:	No				
Name of parent company					
Address Telepho	ne	Fax			
City State	Country	Postal Code			
Does group presently have medical insurance?	Yes 🗆 No				
If yes, please attach the following: Copy of present policy and/or booklet describing benefits. Copy of most recent billing statement from present carrier. Copy of 3 years of most recent claims experience. (In most instances, this can be obtained from you present and/or past carrier(s)) Has another insurance carrier refused your group? Yes No 					
Total number of crew	Are all crew members app	lying? 🗆 Yes 🗆 No			
	If not, why?				
	ii not, why :				
Are any employees presently on COBRA? (If yes, list those employees and list date COBRA began and qualifying event. Attach additional sheets if necessary.)					
Employee					
		Updated 04/1			

Please answer the following questions to the best of your knowledge. If your answer to any question is yes, please give details in the space provided.					
J .	To the best of your knowledge has any employee or dependent suffered from a condition which resulted in a claim of \$2,500 or more during the last 3 years?	□ Yes	🗆 No		
2.	Are any employees or dependents currently pregnant?	🗆 Yes	🗆 No		
3.	Are any employees or dependents presently hospitalized, confined at home or to a treatment facility, disabled or incapacitated?	□ Yes	🗆 No		
4.	Are any employees not actively at work performing his/her normal duties due to illness or injury?	□ Yes	□ No		
5.	Are you aware of any circumstances, chronic or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims?	□ Yes	□ No		

Additional Comments: (Attach additional sheets if necessary)

Employee Census: It is important to provide complete census information for each eligible group member. Initial quotation based on census; final rates based on actual enrollment.

Sex	Name	Status*	Date of Birth	Citizenship		
Status:	tatus: Employee (E) Spouse (S) Dependent Child (D)					

The information provided on this form, including attachments, is intended to provide the company with information necessary to evaluate your group and provide you with premium and coverage indications. Final rates and coverage will be based on the actual enrollment, including evidence of insurability, if applicable. No insurance is in effect unless you are notified in writing by the company. Thank you for your interest in **International Marine Medical Insurance**[™].

Applicant Signature		Date (mo/day/yr)
Agent Signature	Date	Agent Number
Agency	Address	
City	State	Country
Phone	Fax	_Email