

A+MULTINATIONAL REQUEST FOR QUOTE

PLEASE PRINT OR TYPE ALL SECTIONS

Name of Group:	Type of Business:	Telephone:	
		Fax:	
Street Address:		City:	State:
Country:	Postal Code:	Contact Person:	

<p>Does Group presently have group medical coverage? Yes No</p> <p>If yes, please attach the following:</p> <ol style="list-style-type: none"> 1. Copy of policy or booklet describing benefits. 2. Copy of most recent billing statement. 3. Copy of most recent 3 years claims experience.
--

Total number of employees: (Including US based & international employees)	Total number of Eligible employees: (International employees only)
<p>Are any Eligible employees presently residing in the US or Canada? Yes No</p> <p>If Yes, please provide the following information:</p> <p>Employee _____ Expected Date of Departure: _____</p> <p>Employee _____ Expected Date of Departure: _____</p> <p>Employee _____ Expected Date of Departure: _____</p>	
<p>Are any Eligible employees presently on COBRA? Yes No</p> <p>If Yes, please provide the following information:</p> <p>Employee _____ Date/Nature of Qualifying Event: _____</p> <p>Employee _____ Date/Nature of Qualifying Event: _____</p> <p>Employee _____ Date/Nature of Qualifying Event: _____</p>	

Benefit Options Desired:					
Deductible	\$150	\$250	\$500	\$1,000	\$2,500
Maximum Benefit	\$1,000,000	\$5,000,000			
Prescription Drug Card	Yes	No			
Waiting Period – New Employees	30 days	60 days	90 days	other:	

Please answer the following questions to the best of your knowledge. For Yes answers, provide additional details in the space provided.		
1. Has any employee or dependent suffered from a condition, which resulted in a claim of \$5,000 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 currently hospitalized, confined at home, disabled or incapacitated?	Yes	No
4. Are any employees not actively at work performing normal duties due to illness or injury?	Yes	No
5. Are you aware of any circumstances or conditions which can be expected to produce an ongoing claim?	Yes	No
Additional Comments: (attach additional sheets if necessary)		

Employee Census: List each eligible employee, spouse and dependent child. Initial quotation will be based on this census. Final rates will be determined based on actual enrollment. (Attach additional sheets if necessary.)					
Name	Sex	Status *	Date of Birth	Annual Salary	Country
*Status: E=Employee Only ES=Employee and Spouse Only ECH=Employee and Child(ren) Only F=Employee and Spouse and Child(ren)					

Name of Agent:	Company:	Agent Number:
This information is intended to provide MultiNational Underwriters, Inc. with information necessary to provide you with coverage and premium indications. Final rates and coverage will be based on the actual enrollment. No insurance is in effect until you are notified in writing. Thank you for your interest in A+MultiNational.		
Signature:	Printed Name:	
(Authorized representative of group)	Date:	