MULTINATIONAL GROUP BENEFIT PLAN REQUEST FOR QUOTE
(Omitted information may cause delay in the preparation of a proposal for the Group.)

Name of Group:		**Type of Business:**	**Telephone:**
Street Address:		**City:**	**State:**
Country:	**Postal Code:**	**Contact Person:**	
Web site:		**Email:**	

Does employer group presently have domestic and/or international group medical coverage? ☐ Yes ☐ No
If yes, please attach the following:
1. **Copy of policy or booklet describing benefits and/or specific plan details including deductible, lifetime maximum, etc.**
2. **Copy of most recent billing statement.**
3. **Copy of most recent 3 years claims experience and/or 3 years of rates and benefit history.**

The above information is necessary to provide creditable quotes. Please ensure all information is provided.

Total number of employees: **(Including US based & international employees)**	**Total number of Eligible employees:** **(International employees only)**

Are any Eligible employees presently residing in the US or Canada? ☐ Yes ☐ No
If Yes, please provide the following information:

Employee______________________________ Expected Date of Departure:________
Employee______________________________ Expected Date of Departure:________
Employee______________________________ Expected Date of Departure:________

Are any Eligible employees presently on COBRA? ☐ Yes ☐ No
If Yes, please provide the following information:

Employee____________________________ Date/Nature of Qualifying Event:________
Employee____________________________ Date/Nature of Qualifying Event:________
Employee____________________________ Date/Nature of Qualifying Event:________

Benefit Options Desired:	
Deductible	☐ **$150** ☐ **$250** ☐ **$500** ☐ **$1,000** ☐ **$2,500**
Maximum Benefit	☐ **$1,000,000** ☐ **$5,000,000**
Prescription Drug Card (available only through US pharmacies)	☐ **Yes** ☐ **No**

Waiting Period – New Employees	☐ 30 days ☐ 60 days ☐ 90 days ☐ other:
Group Dental Plan	☐ Yes with Orthodontia ☐ Yes without Orthodontia ☐ No
Term Life Face Amount	☐ $10,000 ☐ $25,000 ☐ Other

MNU's privacy policies may be found at www.mnui.com, or contact MNU for a copy.
Please answer the following questions to the best of your knowledge. For Yes answers, provide additional details in the space provided.

Question	Yes	No
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 Producer: Patricia Romero Hamrick	Company: International Insurance-Seguros, Inc.	Producer Number: 99346

This information is intended to provide MultiNational Underwriters, Inc. with information necessary to provide you with competitive rates for medical coverage. 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 the MultiNational Group Benefit Plan.

Signature:	Printed Name:
(Authorized representative of group)	Date: