SRI's International Major Medical Group Quote Request Form

SECTION 1. GENERAL GROUP INFORMATION

GROUP APPLICANT/COMPANY NAME		
ADDRESS		
CITY	**STATE**	**ZIP CODE**
COUNTRY		
CONTACT NAME		
PHONE NUMBER	**FAX NUMBER**	**EMAIL ADDRESS**
NATURE OF BUSINESS	**REQUESTED EFFECTIVE DATE**	

SECTION 2. GROUP ELIGIBILITY

ELIGIBLE EMPLOYEES

Total Number of Employees_____
Total Number of Eligible Employees_____
Total Number of Employees Applying for Coverage_____

WILL COVERAGE BE MANDATORY (all eligible employees will be enrolled)? ☐ **or**
WILL COVERAGE BE VOLUNTARY (all eligible employees will have a choice)? ☐

HAS THE NUMBER OF EMPLOYEES STATED ABOVE INCREASED OR DECREASED BY MORE THAN 10% IN THE PAST 24 MONTHS AND/OR WILL IT INCREASE OR DECREASE BY MORE THAN 10% FOR THE REQUESTED PERIOD OF COVERAGE?
☐ YES OR ☐ NO IF YES, PLEASE EXPLAIN:

PLEASE DEFINE CLASS OR CLASSES OF EMPLOYEES TO WHICH INSURANCE IS TO APPLY IF INSURANCE WILL NOT APPLY TO ALL EMPLOYEES (i.e. Managers, Staff, Executives, etc.).

EMPLOYEE PROFILE BREAKDOWN—For a binding quote and proposal, please attach a complete and accurate census including Dates of Birth, Locations, and Nationalities of all Employees and Eligible Dependents. For a non-binding indication, please provide a summary of Employee Units below.

AGE	MALE EMPLOYEES				FEMALE EMPLOYEES			
	EMPLOYEE ONLY	EMPLOYEE + 1	FAMILY	CURRENT COUNTRY OF RESIDENCE	EMPLOYEE ONLY	EMPLOYEE + 1	FAMILY	CURRENT COUNTRY OF RESIDENCE
19-24								
25-29								
30-34								
35-39								
40-44								
45-49								
50-54								
55-59								
60-64								
65-69								
70+								

SECTION 3. BENEFITS REQUESTED

REQUESTED BENEFIT SCHEDULE ☐ RESIDE Prime Worldwide ☐ RESIDE Worldwide
☐ Custom Plan (Provide Details Below) ☐ To Follow Expiring Plan (Attach present Policy Wording describing Benefits)

DESIRED DEDUCTIBLE PER INSURED PERSON PER POLICY PERIOD
☐$100 ☐$250 ☐$500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐$10,000 ☐$20,000 ☐Other $_____

DESIRED UNDERWRITING METHOD ☐ Individual Underwriting
☐ "12/12" Pre-Ex Clause (Pre-Existing Conditions will not be paid during the first 12 months of this plan.)
☐ Full Take-Over Provision (i.e. No Loss/No Gain. For Take-Over Provision, we **must** receive the detailed claims experience listed below in order to provide a Binding Quote.)

DOES THE EMPLOYER GROUP PRESENTLY HAVE DOMESTIC AND/OR INTERNATIONAL GROUP MEDICAL COVERAGE?
☐ YES OR ☐ NO

If Yes, please attach the following:
1) Present policy wording describing benefits.
2) Most recent billing statement from present carrier.
3) Copy of claims experience during the last three years, which include claims incurred, claims paid, and claims outstanding.
4) Policy Period Dates for all of the above.

ADDITIONAL INFORMATION / MODIFICATIONS TO REQUESTED BENEFIT SCHEDULE:

SECTION 4. AGENT INFORMATION

SRI AGENT# **7235**	AGENT NAME: **Derek Patterson**	
COMPANY NAME: **EGlobalHealth Insurers**		
ADDRESS: **5489 S Westwood Ave**		
CITY: **Springfield**	STATE: **MO**	ZIP CODE: **65810**
EMAIL: **info@eglobalhealth.com**		
PHONE: **417-882-1413**	FAX: **417-459-4623**	

Please be certain to complete this form in full and attach any additional information. Please mail or fax to:
Specialty Risk International, Inc. (SRI)
9200 Keystone Crossing, Suite 300
Indianapolis, IN 46240
Phone: 800-335-0611 Fax: 317-575-2659

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