



**MultiNational Underwriters®**  
Lloyd's Coverholder

**GroupSecure<sup>SM</sup>**  
**Request for Proposal**

(Omitted information may cause delay in the preparation of a proposal)

**Please tell us about your company...**

Desired Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Country / Postal Code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Website (optional): \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

Type of Business: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Medical Coverage Preferences...**  
Standard benefits are indicated with an asterisk (\*). If no options are selected, standard benefits will be included on your proposal.

**Maximum Limit Option**     \$1,000,000 Lifetime     \$5,000,000 Lifetime\*     Other \$ \_\_\_\_\_

**Individual Deductible Options**     \$150     \$250\*     \$500     \$1,000     \$2,500     \$5,000

**Waiting Period - New Employees**     0 Days\*     30 Days     60 Days     90 Days     Other \_\_\_\_\_ Days

**Term Life Face Amount**     \$10,000\*     \$25,000     \$50,000     Other \$ \_\_\_\_\_

**Takeover Provision**     Y     N\*

**US/Canada Coverage**     Y\*     N

**Inside US/Canada – Out-of-Network**     60% of \$5,000     80% of \$5,000\*     90% of \$5,000     Other \_\_\_\_\_ % of \$

**Outside US/Canada & US In-Network**     100%\*     Other \_\_\_\_\_ %

**Dental Plan Benefits...**

<b>I choose to offer...</b>	<input type="checkbox"/> Option 1*	<input type="checkbox"/> Option 2	<input type="checkbox"/> Option 3	<input type="checkbox"/> Other
Plan Maximum	\$1,000	\$1,000	\$1,500	\$
Deductible (Max 3 per family)	\$100	\$50	\$0	\$
Class A - Preventative	100%	100%	100%	%
Class B - Basic Dental Procedures	80%	80%	80%	%
Class C - Major Dental Procedures	50%	50%	50%	%
Orthodontia (\$2,000 Lifetime)	No coverage	50%	50%	%

**Outpatient Prescription Drug Plans...**

<b>I choose to offer...</b>	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2*	<input type="checkbox"/> Option 3	<input type="checkbox"/> Other
Benefit	Drug card (US only): \$15 Co-pay generic \$30 Co-pay brand name (including mail order)	Usual, Reasonable and Customary charges	50% of Usual, Reasonable and Customary charges	
Subject to Deductible and Coinsurance	No**	Yes	Yes	

\*\*When prescription expenses are incurred in the US or Canada without presenting the card at time of purchase, expenses are subject to Deductible and Coinsurance instead of Co-pay

**Additional Options...**

- Preventative Package** Benefits are available after 12 months of coverage and are not subject to Deductible Employees and Dependents age 30 and above: \$250 per Insured Person per Calendar Year  
Female Insured Persons age 40 and over (or qualifying Woman at Risk): \$100 per Insured Person per Calendar Year for a screening mammogram  
Dependent Children under age 19: up to 3 visits (\$75 maximum per visit) for routine wellness
- Emergency Assistance Package** Emergency Medical Evacuation: for Insured Persons under the age of 65
  - Option 1**: \$50,000 Lifetime Maximum\*
  - Option 2**: \$100,000 Lifetime Maximum
  - Option 3**: \$150,000 Lifetime MaximumEmergency Reunion: \$15,000 per Certificate Period  
Repatriation of Remains: \$25,000 Maximum per Insured Person
- Mental Health Disorders** \$25,000 Lifetime Maximum after 12 months of continuous coverage, subject to the following sub-limits:  
Outpatient Treatment: 50% of a maximum charge of \$100 per visit with a maximum of 52 visits per Calendar Year per Insured Person  
Inpatient Treatment: \$10,000 per Calendar Year per Insured Person
- Hospital Indemnity** \$100 per day, seven day maximum (excluding hospitalization for maternity)
- Vision Package** After 12 months of continuous coverage and subject to \$50 Deductible. Covered up to \$150 every 24 months for routine eye exam. Covered up to \$100 every 24 months for corrective lenses, contacts or frames

**Please tell us about your group's eligibility...**

- A. Total number of employees (including US-based & international employees): \_\_\_\_\_
- B. Total number of eligible employees (International employees only): \_\_\_\_\_
- C. Does your group presently have domestic and/or international group medical coverage?  Y  N  
 If yes, please attach the following:  
 1. Copy of policy or booklet describing your benefits and/or specific plan.  
 2. Copy of most recent billing statement.  
 3. Copy of most recent claims experience, rates and benefit history for the past three years.  
 \* The above information is necessary to provide a competitive quote.
- D. Are any eligible employees presently on COBRA?  Y  N  
 If yes, please provide the following information:  
 Employee: \_\_\_\_\_ Date / Nature of the Event: \_\_\_\_\_  
 Employee: \_\_\_\_\_ Date / Nature of the Event: \_\_\_\_\_  
 Employee: \_\_\_\_\_ Date / Nature of the Event: \_\_\_\_\_
- E. Employee Medical Status: Please answer the following questions to the best of your knowledge. For "Yes" answers, provide additional details such as diagnosis, prognosis, treatment (past / current / future) including medication, and degree of recovery.
- 1. Has any Employee or Dependent suffered from a condition that resulted in a claim of \$5,000 or more during the last 3 years?  Y  N
  - 2. Are any Employees or Dependents currently pregnant?  Y  N
  - 3. Are any Employees or Dependents currently hospitalized, confined at home, disabled or incapacitated?  Y  N
  - 4. Are any Employees not actively at work performing normal duties due to Illness / Injury?  Y  N
  - 5. Are you aware of any circumstances or conditions that could result in an ongoing claim?  Y  N

