Print Form

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# MP+INTERNATIONAL REQUEST FOR PROPOSAL

Mission Name_____ Telephone_____

Street Address_____ Contact Person_____

City_____ State_____ Country_____ Postal Code_____

Desired Effective Date_____

What is the employee and/or self-employed filing status with the IRS?

(Check all boxes that apply) ☐ W-2 ☐ 1099 ☐ No Compensation

**BENEFIT PLANS DESIRED**

Deductible Requested: ☐ $100 ☐ $250 ☐ $500 ☐ $1000 ☐ $2500 ☐ $5000

Lifetime Maximum ☐ $1,000,000 ☐ $5,000,000

Life Insurance ☐ $25,000 ☐ $50,000 ☐ Other Amount_____

Agency_____ Agent Name_____ Agent #_____

Address_____ City_____ State_____ Country_____

Telephone_____ Fax_____ Email_____

**Does applicant presently have group medical insurance?** ☐ Yes ☐ No

If yes, please attach the following:

1. Copy of present policy and/or booklet describing benefits.
2. Copy of most recent billing statement from present carrier.
3. Copy of most recent 3 years claims experience.
   (in most instances, this can be obtained from your present and/or past carrier(s))

**Total number of full-time and part-time employees** _____ **Total number of eligible employees & appointed representatives** _____ (including U.S.-based and international employees)

**Member Category (provide count) -**

**1. Employees, work more than 30 hours a week** _____
**2. Volunteers** _____
**3. Self-Employed** _____

**Has another insurance carrier refused your group?** ☐ Yes ☐ No

**How many covered employees & appointed representatives have been employed less than six months?**_____

**Do you expect the number of covered persons to vary by more than 10% during the next 12 months?** ☐ Yes ☐ No

If yes, please explain:_____

**Does your group offer COBRA?** ☐ Yes ☐ No

**Are any covered persons presently on COBRA?** ☐ Yes ☐ No

(If yes, please list names and the date COBRA began along with the qualifying event. Attach additional sheets if necessary).

Name_____ Date Cobra began_____

Name_____ Date Cobra began_____

Name_____ Date Cobra began_____

**Please answer the following questions. If your answer to any of these questions is yes, please provide details in the space provided below.**

1. Has any person to be covered under this plan, including dependents suffered from a condition which resulted in a claim of $2,500 or more during the last 3 years? ☐ Yes ☐ No
2. Is any person to be covered under this plan, including dependents currently pregnant? ☐ Yes ☐ No
3. Is any person to be covered under this plan, including dependents presently hospitalized, confined at home or treatment facility, disabled or incapacitated? ☐ Yes ☐ No
4. Is any person to be covered under this plan, including dependents 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 that each person to be covered be included on this census. The initial quotation is based on this census. Final rates are based on actual enrollment.

| Sex | Name | Pay Type* | Status** | Date of Birth | Hire Date | Annual Salary | Country of Residence |
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Provide names of any U.S. Veterans:_____

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***Pay Type: Employee (E) Volunteer, Self-Employed Contractors or other Non-Compensated Mission Affiliates (V)**
****Status: Primary Insured (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 MP+ International.

Applicant Signature_____ Date_____

Agent Signature_____ Date_____