

Request for Proposal

PART 1. Prospective participating organization ("APPLICANT")			
Participating Organization Name:		Authorized Representative Contact:	
Telephone:		Email:	
Street Address:			City:
State/Province:	Country:	Postal/Zip Code:	Requested Effective Date <small>(MM/DD/YYYY):</small>
Industry:		Type of Work Employees Perform:	
Total Number of Eligible International Employees:		Total Number of U.S. Citizens Included in Census:	Total Number of Local Nationals Included in Census:
Is the company/organization a subsidiary or division of a U.S. or Canadian corporation? If Yes, U.S. or Canadian?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any employees/dependents currently residing in the U.S. or Canada? If Yes, please provide details in census section.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you expect the number of employees to vary in the next 12 months? If Yes, please provide details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the company currently have or offer medical insurance? If Yes, please provide name of carrier, current and renewal rates, schedule of benefits, and three years of claims experience, if available.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has another insurance company refused to quote, terminated, or declined to offer coverage to the organization or its participants? If Yes, please provide details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any employees or dependents presently covered under COBRA or other continuation plans? If Yes, please indicate those individuals in the census.			<input type="checkbox"/> Yes <input type="checkbox"/> No
If local nationals are applying for coverage, will the employees be travelling outside of their country of residence? If Yes, how often? For how long?			<input type="checkbox"/> Yes <input type="checkbox"/> No
PART 2. Requested Plan Benefits			
Non-U.S. Deductible: <input type="checkbox"/> \$0 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other: \$ _____			
U.S. Deductible: <input type="checkbox"/> \$0 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other: \$ _____			
Maximum Deductible: <input type="checkbox"/> 2 per Family <input type="checkbox"/> 3 per Family			
Coverage Area (Choose One): <input type="checkbox"/> Worldwide <input type="checkbox"/> Custom – Please indicate countries covered: _____ <input type="checkbox"/> Worldwide Excluding* the U.S., Canada, China, Hong Kong, Japan, Macau, Singapore and Taiwan <small>*Except 30 days emergency/accident</small>			
Additional Benefits Upon Request: <input type="checkbox"/> Adventure Sports Rider <input type="checkbox"/> Dental <input type="checkbox"/> Platinum USA Benefit Rider <input type="checkbox"/> Creditable Coverage Offset <input type="checkbox"/> Daily Hospital Indemnity <input type="checkbox"/> Other: _____ <input type="checkbox"/> Long-term Disability* (Please submit complete Disability Questionnaire) <input type="checkbox"/> Guarantee Issue <small>*Disability products are administered and underwritten by Zurich American Life Insurance Company</small> For New Employees			
Additional Assistance Services Upon Request: <input type="checkbox"/> Remote Mental Health Services <input type="checkbox"/> Teleconsultation			
Lifetime Maximum: <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$5,000,000 <input type="checkbox"/> \$8,000,000 <input type="checkbox"/> Other: \$ _____			
Life Insurance Benefit: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> 1 x Salary to maximum of \$ _____ <input type="checkbox"/> 2 x Salary to maximum of \$ _____ <input type="checkbox"/> 3 x Salary to maximum of \$ _____ <input type="checkbox"/> Other \$ _____ <small>(2-10 lives, \$10,000 minimum required). Maximum available guaranteed issue is \$100,000.</small>			
Implementation needs: <input type="checkbox"/> Reporting _____ <input type="checkbox"/> Enrollment _____			

**PART 3. Please answer the following questions. (If your answer to any question is Yes, please give details in the space provided. Attach additional pages as necessary.)**

1. Has any employee or dependent suffered from an injury, illness or other medical/health condition that resulted in total claims, expenses, or costs of \$2,500 or more during the last three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are any employees or dependents currently hospitalized, confined at home or a treatment facility, disabled or incapacitated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are any employees or dependents currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are any employees or dependents not able to work or perform activities of daily living due to illness, injury or other medical/health condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you aware of any circumstances, chronic, congenital, terminal, pre-existing, or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims, expenses, or costs for any employees or dependents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have any employees or dependents been diagnosed with or been treated for COVID-19? If yes, please answer the following: <b>a) Were they hospitalized?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>b) Were they in intensive care?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part 4. Census summary (Required for groups of 100 lives or more)**

AGE	MALE				FEMALE			
	Employee	Employee+ Spouse	Employee+ Child(ren)	Employee+ Family	Employee	Employee+ Spouse	Employee+ Child(ren)	Employee+ Family
19-24								
25-29								
30-34								
35-39								
40-44								
45-49								
50-54								
55-59								
60-64								
65-69								
70+								

\*Status: Employee only (E) Employee+ Spouse (ES) Employee+ Child(ren) (EC) Employee+ Family (EF) (attach additional pages as necessary)

\*\*Provide salary only if a proposal is desired for life insurance coverage based upon a multiple of salary

\*\*\*Defined as a category of employees with easily distinguishable and identifiable common characteristics (i.e. management, non-management, hourly, salary, exempt, non-exempt, or sales)

