



## A+ MultiNational Request for Quote

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

Name of Group:		Type of Business:	Telephone:
			Fax:
Street Address:		City:	State:
Country:	Postal Code:	Contact Person:	
Web site:		E-mail:	

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 U.S. based and international employees)	Total number of Eligible employees: (international employees only)
Are any Eligible employees presently residing in the U.S. or Canada? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> \$150.00	<input type="checkbox"/> \$250.00	<input type="checkbox"/> \$500.00	<input type="checkbox"/> \$1,000.00	<input type="checkbox"/> \$2,500.00
Maximum Benefit	<input type="checkbox"/> \$1,000,000.00		<input type="checkbox"/> \$5,000,000.00		
Prescription Drug Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Waiting Period—New Employees	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> Other	
Term Life Face Amount	<input type="checkbox"/> \$10,000.00	<input type="checkbox"/> \$25,000.00	<input type="checkbox"/> Other		

**MNU's privacy policies may be found at [www.mnui.com](http://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.

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are any employees or dependents currently pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are any employees or dependents currently hospitalized, confined at home, disabled or incapacitated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are any employees not actively at work performing normal duties due to illness or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Are you aware of any circumstances or conditions which can be expected to produce an ongoing claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	Gender	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 Agent:

Maria Karlsson

Company:

International Ins.

Agent Number:

22297

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 A+MultiNational Group benefit plan.

Signature:

Printed Name:

(Authorized representative of group)

Date: