Special Group Travel Request for Proposal

To be completed by producer

INTERNATIONAL MEDICAL GROUP

DEMOGRAPHIC INFORMATION	
Sponsoring Organization:	
Describe Organization:	
Number of Proposed Insureds:	Average Age of Proposed Insureds:
Citizenship *(Percent or Number)*: U.S.: Non-U.S.:	
Requested Effective Date *(MM,DD,YY)*:	Length of Coverage:
Destinations:	
How Long Has Coverage Been in Force *(If applicable)*:	Reason for Change in Carrier *(If applicable)*:
Competitors Quoting *(If known)*:	

COVERAGE INFORMATION - *Please attach information if available*					
Current Coverage: ❑ Yes *(Carrier Name):* ❑ No				Copy of Current Plan Design: ❑ Yes ❑ No	
Rate History with Enrollment Numbers: ❑ Yes ❑ No *(Preferably last three years)*				Loss Ratio/Claims Information: ❑ Yes ❑ No *(Preferably last three years)*	
Proposed Group Plan: ❑ Patriot Travel ❑ Patriot Exchange ❑ Student Health Advantage ❑ Patriot Green ❑ Patriot Platinum ❑ Patriot Multi-Trip ❑ Sky Rescue					
Maximum Benefit Amount(s):	$	$	$	Type: ☑ Lifetime ❑ Per Illness/Injury	
Deductible(s) Amount:	$ 0	$	$	Type: ❑ Calendar Year ❑ Per Illness/Injury ❑ Per Period	
Coinsurance Amount(s):	❑ 80/20	❑ 90/10	❑ 100/0	❑ Other	Maximum out-of-pocket:
Rate Mode:	❑ Annual	❑ Monthly	❑ Daily	Type: ❑ Composite ❑ Age-banded	
Payment Method:	❑ Event	❑ Monthly	Optional Riders/Coverage(s):		

PRODUCER INFORMATION		
Producer Name:	Producer Number:	Parent Number *(If applicable)*:
Are You the Current Agent of Record: ❑ Yes ❑ No *(Relationship to group)*:	Current Commission: %	Date of Request *(MM, DD, YY)*:
Notes:		

HOME OFFICE USE ONLY	
Date RFP was Received *(MM, DD, YY)*:	Account Executive:
Date Sent to Underwriting *(MM, DD, YY)*:	Manager Approval:

Please send information to:
VisitorsCoverage Inc., 2350 Mission College Blvd. Ste 1140, Santa Clara, CA 95054 USA
OR Fax it to: 1.408.496.1090
OR Email: insurance@visitorscoverage.com

www.VisitorsCoverage.com
Producer # 472382