

Good Neighbor Insurance
690 E. Warner Rd. Ste 117,
Gilbert, AZ 85296
Tel: 480-813-9100 / Fax 480-813-9930
E-MAIL: jeff@gninsurance.com
WEBSITE:www.gninsurance.com

REQUEST FOR GROUP QUOTE/PROPOSAL
FOR OVERSEAS MEDICAL INSURANCE

Please Print or Type All Sections

Organization Name _____	
Street Address _____	Contact Person _____
City _____	State _____ Postal Code _____ Country _____
Phone Number _____	E-mail _____
Nature of Business _____	Desired Effective Date _____
BENEFIT PLANS DESIRED	
Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000	
Lifetime Maximum: <input type="checkbox"/> \$1,000,00 <input type="checkbox"/> \$5,000,000	
Life Insurance: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> Other _____	
Waiting Period - <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> Other _____	
New Employees	
Are any employees presently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide the following information. (Attach additional sheets if necessary.)	
Employee _____	Date of Departure _____
Employee _____	Date of Departure _____
Employee _____	Date of Departure _____
Employee _____	Date of Departure _____
Has another insurance carrier refused your group	

international medical insurance coverage? Yes No

Total number of employees _____ Total number of eligible employees _____
 (including US-based & intl. employees) (intl. employees only)

How many employees have been employed less than six months? _____

Do you expect the number of employees to vary more than 10% during the next 12 months?

If YES, please explain _____

What is the employee and/or self-employed filing status with the IRS?
 (Check all boxes that apply) W-2 1099 No Compensation

Does your group presently have international health 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 or past carrier(s))

Please answer the following questions to the best of your knowledge. If you answer YES to any of these questions, please provide details in the space provided below.

1. Has any employee or dependent suffered from a condition which resulted in a claim of \$2500 or more during the last 3 years? Yes No
2. Are any employees or dependents currently pregnant? Yes No
3. Are any employees or dependents presently hospitalized, confined at home or treatment facility, disabled or incapacitated? Yes No
4. Are any employees 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: List each eligible employee, spouse, and dependent child. Initial quote will be based on this census. Final rates will be determined based on actual enrollment. (Attach additional sheets if necessary.)

