



# GroupSecure<sup>SM</sup> Request for Proposal

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

## Please tell us about your company...

Desired Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Country / Postal Code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Website (optional): \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

Type of Business: \_\_\_\_\_ E-mail: \_\_\_\_\_

## Medical Coverage Preferences...

Standard benefits are indicated with an asterisk (\*). If no options are selected, standard benefits will be included on your proposal.

Maximum Limit Option	<input type="checkbox"/> \$1,000,000 Lifetime	<input type="checkbox"/> \$5,000,000 Lifetime*	<input type="checkbox"/> Other \$ _____
Individual Deductible Options	<input type="checkbox"/> \$150	<input type="checkbox"/> \$250*	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Waiting Period - New Employees	<input type="checkbox"/> 0 Days*	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> Other _____ Days
Term Life Face Amount	<input type="checkbox"/> \$10,000*	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$50,000 <input type="checkbox"/> Other \$ _____
Takeover Provision	<input type="checkbox"/> Y	<input type="checkbox"/> N*	
US/Canada Coverage	<input type="checkbox"/> Y*	<input type="checkbox"/> N	
Inside US/Canada – Out-of-Network	<input type="checkbox"/> 60% of \$5,000	<input type="checkbox"/> 80% of \$5,000*	<input type="checkbox"/> 90% of \$5,000 <input type="checkbox"/> Other _____ % of \$
Outside US/Canada & US In-Network	<input type="checkbox"/> 100%*	<input type="checkbox"/> Other _____ %	

## Dental Plan Benefits...

I choose to offer...	<input type="checkbox"/> Option 1*	<input type="checkbox"/> Option 2	<input type="checkbox"/> Option 3	<input type="checkbox"/> Other
Plan Maximum	\$1,000	\$1,000	\$1,500	\$
Deductible (Max 3 per family)	\$100	\$50	\$0	\$
Class A - Preventative	100%	100%	100%	%
Class B - Basic Dental Procedures	80%	80%	80%	%
Class C - Major Dental Procedures	50%	50%	50%	%
Orthodontia (\$2,000 Lifetime)	No coverage	50%	50%	%

## Outpatient Prescription Drug Plans...

I choose to offer...	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2*	<input type="checkbox"/> Option 3	<input type="checkbox"/> Other
Benefit	Drug card (US only): \$15 Co-pay generic \$30 Co-pay brand name (including mail order)	Usual, Reasonable and Customary charges	50% of Usual, Reasonable and Customary charges	
Subject to Deductible and Coinsurance	No**	Yes	Yes	

\*\*When prescription expenses are incurred in the US or Canada without presenting the card at time of purchase, expenses are subject to Deductible and Coinsurance instead of Co-pay

**Additional Options...**

**Preventative Package** Benefits are available after 12 months of coverage and are not subject to Deductible  
Employees and Dependents age 30 and above: \$250 per Insured Person per Calendar Year  
Female Insured Persons age 40 and over (or qualifying Woman at Risk): \$100 per Insured Person per Calendar Year for a screening mammogram  
Dependent Children under age 19: up to 3 visits (\$75 maximum per visit) for routine wellness

**Emergency Assistance Package** Emergency Medical Evacuation: for Insured Persons under the age of 65  
 **Option 1:** \$50,000 Lifetime Maximum\*  
 **Option 2:** \$100,000 Lifetime Maximum  
 **Option 3:** \$150,000 Lifetime Maximum  
Emergency Reunion: \$15,000 per Certificate Period  
Repatriation of Remains: \$25,000 Maximum per Insured Person

**Mental Health Disorders** \$25,000 Lifetime Maximum after 12 months of continuous coverage, subject to the following sub-limits:  
Outpatient Treatment: 50% of a maximum charge of \$100 per visit with a maximum of 52 visits per Calendar Year per Insured Person  
Inpatient Treatment: \$10,000 per Calendar Year per Insured Person

**Hospital Indemnity** \$100 per day, seven day maximum (excluding hospitalization for maternity)

**Vision Package** After 12 months of continuous coverage and subject to \$50 Deductible. Covered up to \$150 every 24 months for routine eye exam. Covered up to \$100 every 24 months for corrective lenses, contacts or frames

**Please tell us about your group's eligibility...**

A. Total number of employees (including US-based & international employees): \_\_\_\_\_  
 B. Total number of eligible employees (International employees only): \_\_\_\_\_

C. Does your group presently have domestic and/or international group medical coverage?  Y  N  
 If yes, please attach the following:  
 1. Copy of policy or booklet describing your benefits and/or specific plan.  
 2. Copy of most recent billing statement.  
 3. Copy of most recent claims experience, rates and benefit history for the past three years.

\* The above information is necessary to provide a competitive quote.

D. Are any eligible employees presently on COBRA?  Y  N  
 If yes, please provide the following information:

Employee: \_\_\_\_\_ Date / Nature of the Event: \_\_\_\_\_  
 Employee: \_\_\_\_\_ Date / Nature of the Event: \_\_\_\_\_  
 Employee: \_\_\_\_\_ Date / Nature of the Event: \_\_\_\_\_

E. Employee Medical Status: Please answer the following questions to the best of your knowledge. For "Yes" answers, provide additional details such as diagnosis, prognosis, treatment (past / current / future) including medication, and degree of recovery.

1. Has any Employee or Dependent suffered from a condition that resulted in a claim of \$5,000 or more during the last 3 years?  Y  N
2. Are any Employees or Dependents currently pregnant?  Y  N
3. Are any Employees or Dependents currently hospitalized, confined at home, disabled or incapacitated?  Y  N
4. Are any Employees not actively at work performing normal duties due to Illness / Injury?  Y  N
5. Are you aware of any circumstances or conditions that could result in an ongoing claim?  Y  N

