



International Medical Group®, Inc.
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MP+INTERNATIONAL REQUEST FOR PROPOSAL

Mission Name Telephone
Street Address Contact Person
City State Country Postal Code
Desired Effective Date

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

BENEFIT PLANS DESIRED

HIPAA compliant for appointed representatives (volunteers & self employed receiving 1099), requires 80% of appointed representatives [] Yes [] No
Deductible Requested: [] \$100 [] \$250 [] \$500 [] \$1000 [] \$2500 [] \$5000
Lifetime Maximum [] \$1,000,000 [] \$5,000,000
Life Insurance [] \$25,000 [] \$50,000 [] Other Amount

Agency Agent Name Agent #
Address City State Country
Telephone Fax Email

Does applicant presently have group medical 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 and/or past carrier(s))

Total number of full-time and part-time employees Total number of eligible employees & appointed representatives (including U.S.-based and international employees)

Member Category (provide count) -
1. Employees, work more than 30 hours a week
2. Volunteers
3. Self-Employed

Has another insurance carrier refused your group? [] Yes [] No

How many covered employees & appointed representatives have been employed less than six months?

Do you expect the number of covered persons to vary by more than 10% during the next 12 months? [] Yes [] No
If yes, please explain:

Does your group offer COBRA? [] Yes [] No
Are any covered persons presently on COBRA? [] Yes [] No
(If yes, please list names and the date COBRA began along with the qualifying event. Attach additional sheets if necessary).

Name Date Cobra began
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Name Date Cobra began

