HCC Medical Insurance Services
Lloyd's Coverholder

GroupSecure℠
Request for Proposal

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

Global Medical Insurance GMI

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

Dental Plan Benefits…

I choose to offer…	☐ Option 1*	☐ Option 2	☐ Option 3	☐ 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…	☐ Option 1	☐ Option 2*	☐ Option 3	☐ 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

HCC Medical Insurance Services
251 North Illinois Street, Suite 600 / Indianapolis, IN 46204
317-262-2132 / 800-605-2282 / Fax 317-262-2140 / insurance@hccmis.com

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

HCC Medical Insurance Services
251 North Illinois Street, Suite 600 / Indianapolis, IN 46204
317-262-2132 / 800-605-2282 / Fax 317-262-2140 / insurance@hccmis.com

Additional Comments: (attach additional sheets if necessary)

Employee Census: List each eligible Employee, Spouse and Dependent Child(ren). Initial proposal will be based on this census. Final rates will be determined based on actual enrollment. (Attach additional sheets if necessary)

Name	Gender	Date of Birth (DOB)	Status*	Spouse Date of Birth (if covered)	Number of Children (if covered)	Annual Salary**	Residence	Citizenship

***Status:** **E**=Employee Only **ES**=Employee and Spouse Only **ECH**=Employee and Child(ren) Only **F**=Employee, Spouse and Child(ren)

****Required if Term Life amount is based on salary**

Signature: This information is intended to provide HCC Medical Insurance Services (HCCMIS) with information necessary to provide you with competitive rates for medical coverage. Final rates and coverages will be based on the actual enrollment. No insurance is in effect until you are notified by HCCMIS in writing. Thank you for your interest in GroupSecure℠.

Signature: (Authorized representative of group)	Printed Name: Date:

HCCMIS's privacy policy may be found by visiting www.hccmis.com or by contacting HCCMIS for a copy.

Producer Information:

Producer Name: **GMI - Moshe Sharan**	Company Name:	
Producer Number: **99910-0015**	Telephone:	Fax:
Street Address:	City:	State/Province:
	Postal Code:	Country:
E-mail Address: **info@gmi100.com**	Signature:	