SUBMISSION DATE:        QUOTE DATE:

NAME OF ORGANIZATION:

STREET ADDRESS:

CITY:        STATE:        ZIP:

PLEASE PROVIDE THE TOTAL NUMBER OF PERSONS TO BE COVERED:

EMPLOYEES        CONSULTANTS

OTHER        EXPLAIN:

|  |  |  |
| --- | --- | --- |
|  | TO US DESTINATIONS  FOR NON US EMPLOYEES TRAVELING INTO THE US | TO NON US DESTINATIONS |
| A) NUMBER OF TRAVELERS PER TRIP |  |  |
| B) ESTIMATED TOTAL NUMBER OF TRIPS |  |  |
| C) AVERAGE DURATION OF EACH TRIP IN DAYS |  |  |
| TOTAL TRAVEL DAYS  (A X B X C) |  |  |

|  |  |  |
| --- | --- | --- |
| PLEASE LIST ALL COUNTRIES TO WHICH TRAVEL OCCURS. PLEASE USE A SEPARATE SPREADSHEET IF NECESSARY | | |
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BENEFIT OPTIONS:

|  |  |  |
| --- | --- | --- |
| MEDICAL PLAN | OPTION 1 | OPTION 2 |
| MEDICAL MAXIMUM:  Choose an amount up to $250,000 | $ | $ |
| DEDUCTIBLE PER OCCURRENCE:  Choose $25, $50, $100, $250, $500, $1000 | $ | $ |
| CO-INSURANCE:  None or 80/20 |  |  |
| CO-INSURANCE MAXIMUM:  Choose $0, $1,000, $2,500, $5,000 | $ | $ |
| HOSPITAL ROOM & BOARD (Intensive care is 2 x benefits):  Average Semi-Private | Average Semi-Private | Average Semi-Private |
| PLAN DESIGN | OPTION 1 | OPTION 2 |
| ACCIDENTAL DEATH & DISMEMBERMENT:  Choose from $10,000 to $500,000  \*Available alone or with Medical Plan | $ | $ |
| MEDICAL EVACUATION:  Included | 100% Covered | 100% Covered |
| REPATRIATION:  Included | 100% Covered | 100% Covered |

WAR RISK TRAVEL DATA

WAR RISK TRAVEL DATA

|  |  |  |  |
| --- | --- | --- | --- |
| WAR RISK COUNTRY | NUMBER OF EMPLOYEES WHO TRAVEL TO DESTINATION | NUMBER OF TRIPS | DURATION OF EACH TRIP |
| AFGHANISTAN |  |  |  |
| ALGERIA |  |  |  |
| CENTRAL AFRICAN REPUBLIC |  |  |  |
| CHAD |  |  |  |
| CHECHNYA |  |  |  |
| DEMOCRATIC REPUBLIC OF CONGO |  |  |  |
| EGYPT |  |  |  |
| GUINEA |  |  |  |
| IRAQ |  |  |  |
| ISRAEL |  |  |  |
| IVORY COAST |  |  |  |
| LIBYA |  |  |  |
| MALI |  |  |  |
| NIGERIA |  |  |  |
| PAKISTAN |  |  |  |
| SOMALIA |  |  |  |
| SOUTH SUDAN |  |  |  |
| SUDAN |  |  |  |
| SYRIA |  |  |  |
| UKRAINE |  |  |  |
| YEMEN |  |  |  |

PRIOR COVERAGE:

IF NO PRIOR COVERAGE, PLEASE CHECK HERE ☐

INSURANCE COMPANY NAME:

EFFECTIVE DATE:       RENEWAL DATE:

PLEASE PROVIDE DETAILS OF THE CURRENT PROGRAM, INCLUDING COVERAGE, BENEFITS, COPY OF CURRENT POLICY AND A MINIMUM OF (3) YEARS PREMIUM AND LOSS HISTORY. PLEASE PROVIDE DETAILED CLAIMS DATA FOR ALL RISK WITH A PREMIUM OF $50,000 OR HIGHER.

BROKER INFORMATION:

AGENCY NAME:

AGENCY ADDRESS:

CONTACT NAME:

TELEPHONE:       FAX:

E-MAIL:

COMMISSION %:

**SHOULD YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT:**