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 DESTINATIONSFOR 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 |
|        |        |        |
|        |        |        |
|        |        |        |
|        |        |        |
|        |        |        |
|        |        |        |
|        |        |        |
|        |        |        |

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:**