

**ACCIDENT & MEDICAL GROUP QUOTE REQUEST**

Send to: specialrisk@globalunderwriters.com

Date: \_\_\_\_\_

Quote Due Date: \_\_\_\_\_

From: \_\_\_\_\_

Email: \_\_\_\_\_

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

City, State: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Fax #: \_\_\_\_\_

<b>Name of Client (Group):</b>	
<b>Address:</b>	
<b>City/State/Zip:</b>	
<b>Description of job, trip, or risk:</b>	<b>Age (# of participants in each age range):</b> 14 Days -19 _____ 20-30 _____ 31-35 _____ 36-40 _____ 41-55 _____ 56-69 _____ 70+ _____
<b>Estimated Annual Participants:</b> Inbound _____ and/or _____ Outbound _____ Total _____ Total _____	<b>Anticipated Policy Period:</b>
<b>Traveling From:</b>	<b>Traveling To:</b>
<b>Duration of trips, Countries visited, Length of stay in each country, (use next page to explain)</b>	

\*Please also complete the attached census form.

<b>BENEFITS</b>	<b>BENEFIT MAXIMUMS/OPTIONS (Circle One)</b>
<b>Accident/Sickness Medical:</b>	\$25K, \$50K, \$100K, \$150K, \$250K, \$500K, \$1Mil
<b>Deductible:</b>	\$0, \$25, \$50, \$100, \$250, \$500, \$1,000, \$5,000
<b>Coinsurance:</b>	100%; 80/20% to \$5,000, 80/20% to \$10,000
<b>AD&amp;D:</b>	\$10,000 Minimum Other \$ _____
<b>Emergency Med-Evac:</b>	\$15K, \$25K, \$50K, \$75K, \$100K, \$200K, \$300K
<b>Repatriation of Remains:</b>	\$10K, \$15K, \$20K, \$25K, \$50K Other: \$ _____

<b>Emergency Reunion:</b>	\$2K, \$3K, \$5K, Other: \$ _____
<b>Trip Cancellation:</b>	Complete the Trip Cancellation Questionnaire
<b>Dental – Sudden Onset of Pain:</b>	\$100, \$150, Other: \$ _____
<b>War Risk Coverage:</b>	Yes _____ No _____
<b>Kidnap &amp; Ransom Coverage:</b>	Yes _____ No _____
<b>Foreign Liability Coverage:</b>	Yes _____ No _____
<b>Political &amp; Natural Disaster Evacuation Coverage:</b>	Yes _____ No _____ Amount Requested _____ (50K Max)
<b>Unusual/Hazardous Exposures:</b>	Yes _____ No _____ e.g. Hang Gliding, Mountain Climbing, etc. Describe: _____
<b>Sports Coverage:</b>	Yes _____ No _____ e.g. Snow Skiing, Soccer, Basketball, etc. Describe: _____
<b>Home Country Coverage:</b>	Yes _____ No _____
<b>Pre-X:</b>	3 Month, 6 Month, 1 year, 2 years, 3 years Other: _____
<b>Unexpected Recurrence of Pre-X</b>	Yes _____ No _____
<b>24 Hour Assistance Services:</b>	Yes _____ No _____
<b>Rates:</b>	Daily, Weekly, Yearly
<b>Miscellaneous:</b>	

**Prior Loss History**

<b>Carrier Name:</b>				
<b>Policy Year:</b>				
<b>Earned Premium:</b>				
<b>Incurred Claims:</b>				
<b>Completed Loss Ratio:</b>				

**Additional Information:** \_\_\_\_\_

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