Global UNDERWRITERS
International Travel/Medical Insurance
3195 Linwood Rd. Suite 201 800-423-8496
Cincinnati, Ohio 45208 F 513-533-1504
www.globalunderwriters.com

Global Expatriate Benefits Insurance Application

INSTRUCTIONS: Employers please complete items 1-9 below.

1. Employer's Contact Information

Employer Name _____
Street _____
City _____ State/Country _____ ZIP/Postal Code _____
Contact Name _____ Contact Title _____
Telephone Number _____ Fax Number _____
Email Address _____

2. Type of Business _____
Number of Years in Business _____ SIC/NAICS Code _____

3. Plan Design Options Selected
(Please select one choice from each category A-E below - Inclusion of a Medical Plan is required.)

A. Medical
- ☐ PPO
- ☐ OAMC
- ☐ Indemnity

B. Dental Plan
- ☐ Without orthodontia *
- ☐ With orthodontia *
- ☐ None

C. Life Plan
Flat Amount or Earnings Related
- ☐ $10,000
- ☐ $25,000
- ☐ $50,000
- ☐ None
- ☐ 1 x salary

D. AD&PL Plan
(Same as life benefits)
- ☐ Include
- ☐ None

E. LTD Plan
- ☐ Coverage as follows:
  - ☐ % Benefit
  - ☐ Maximum Monthly Benefit
  - ☐ Elimination Period
- ☐ None

4. Requested effective date of plan _____

5. Number of International eligible employees _____

6. Number of International eligible dependents _____

7. Broker Contact Information

Broker Company Name _____
Broker U.S. Tax Identification Number (TIN) _____
Broker Contact Name _____
Telephone Number _____ Fax Number _____
Email Address _____

8a. Are all employees employed by the Plan Sponsor noted in section "1. Employer's Contact Information"?

☐ No ☐ Yes If No, explain who the employee's employer is, and provide the employer details including name and address/country, along with the employee listing (census).

_____

8b. Payment Options

Are there sources of premium other than the Plan Sponsor noted in section "1. Employer's Contact Information"?

☐ No ☐ Yes If Yes, explain the source(s).

_____
_____

9. Employer Signature _____ Date _____

Include area, city, and country code(s), as applicable.

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INSTRUCTIONS: Employers please complete items 1-3 below.

General Information

1. Carrier/Plan Information:
   A. ☐ No ☐ Yes Has group been previously insured for group coverage?
   If Yes, provide Name of Carrier_____.

2. Member Identification (ID) Cards:
   A. Name of Company to appear on ID Card: _____
   B1. Distribution for ID Cards:
   ☐ In Bulk to Policyholder – see B2 below ☐ Directly to Members*
   B2. Should this method be used for the initial delivery only? ☐ No ☐ Yes
   If Yes, please describe: _____

*If delivered directly to members, we utilize the address given to us on the member's eligibility record (form/spreadsheet).

3. Eligibility/Participation:
   A. _____ Total number of employees employed by your company
   B. _____ Total number of eligible employees
   C. _____ Total number of eligible employees applying for coverage
   D. _____ Total number of eligible dependents
   E. _____ Total number of eligible dependents applying for coverage

Please retain a copy for your records.