

In order to facilitate a Group quotation, please complete the following form and forward either by e-mail to enquiries@healthcareinternational.com or by fax to +44 (0)20 7590 8815. You can also post or courier this form directly to the following address:

HealthCare International,
UK Administration,
95 Cromwell Road,
SW7 4DL,
United Kingdom

Name of Group: _____

Date: _____ Country (source of request): _____

A. Group Contact Information

1) Full Name of Corporation/Group: _____

Mailing Address: _____

City: _____ Postal Code: _____

Province/State: _____ Country: _____

Telephone: _____ Fax: _____

E-mail: _____

General Nature of the Business (detailed description): _____

Specific Activity or Occupation of Group to be insured: _____

2) Consultant/Broker Contact Information (if applicable)

Full Name of Contact Person: _____

Title/Job: _____ E-Mail: _____

Telephone: _____ Fax: _____

3) Group Profile (choose one of the following)

Corporation

Association

International Institution

Government Organisation

Company Voluntary

Educational Institution

Other Group Affiliated (please describe): _____

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

B. Group General Information

1) Membership in Group

Obligatory (all eligible members)

Voluntary (some eligible members)

Other (please describe): _____

2) Employees

Number of Employees to be insured: _____

Approximate Number of Dependents to be insured: _____

Please list the countries where most employees currently live and work:

Work-location Countries or Regions:

Family Residence Countries:

i) _____ i) _____

ii) _____ ii) _____

iii) _____ iii) _____

iv) _____ iv) _____

v) _____ v) _____

What are the main nationalities of the employees who are going to be insured?

i) _____ ii) _____

iii) _____ iv) _____

v) _____ vi) _____

3) Categories to be Insured (choose one):

Managers only

All Employees

All Expatriate Employees

Combinations or other possibilities (please describe): _____

4) Mobility of Employees (choose one):

Permanent Residents

Expatriate Staff

Short International Missions (less than 3 months)

Combinations or other possibilities (please describe): _____

5) Eligibility of Dependents for Insurance (choose one):

Employees only

Employees and Family Members

Combinations or other possibilities (please describe): _____

6) Commencement/Renewal of Cover

All on same date (specify month and year): _____

On different dates (please describe): _____

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

C. Group Insurance Information

1) What insurance benefits are of interest for the Group? Please choose as many as the Group is seriously interested in.

- Medical
- Comprehensive Health Care (includes dental and vision care)
- Medical Evacuation and Assistance Services
- Accidental Death and Disability (A.D. & D.)
- Term Life Insurance
- Voluntary A.D. & D. / Term Life Insurance (in addition to the company cover)
- Short-term Disability (more than 50 employees)
- Long-term Disability (more than 50 employees)
- Travel Insurance
- Other (please describe): _____

2) How would you describe the Group's immediate medical and employee benefit insurance needs today, or in the next twelve months?

3) Please note the main features which the Group wishes to find in a new program (e.g. customer service, benefits):

- i) Service: _____
- ii) Benefits: _____
- iii) Policy Terms and Conditions: _____
- iv) Price: _____

4) What does the Group NOT LIKE in their present insurance situation?

- i) No Insurance Cover: _____
- ii) Service: _____
- iii) Benefits: _____
- iv) Policy Terms and Conditions: _____
- v) Price: _____

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

C. Group Insurance Information - continued

5) Is the Group currently insured for medical benefits (or was it insured during the last 12 months)?

No Yes (please describe): _____

Name of Insurer: _____

Period of Insurance: _____

Nature of Benefits (or name of plan): _____

Price of Plan (and currency): _____

Number of Employees on the Plan: _____

6) Please indicate the total amount of medical claims which were paid for the Group during the last three years, starting with the current year and including the incurred but not reported (IBNR) estimate of claims for the current year:

Year: _____ Medical Claims: _____

Year: _____ Medical Claims: _____

Year: _____ Medical Claims: _____

7) Please provide details of any individual medical, or related, claim or loss incurred during the last three years, which extended to more than 10,000 US Dollars (or equivalent in another currency) within a 12 month period:

Date of Treatment: _____ to _____

Condition Treated: _____

Total Amount of Claim in the Aggregate: _____

(If more claims of this nature exist, please attach a separate page which must be signed and dated)

D. List of Employees to be Insured

A convenient way to send us this information is with a Spreadsheet (e.g. Microsoft Excel) sent by fax to +44 (0)20 7590 8815 or by e-mail to enquiries@healthcareinternational.com. Alternatively, post the list along with this form to HealthCare International, UK Administration, 95 Cromwell Road, London, SW7 4DL, United Kingdom.

Include for each Employee:

- Gender (male / female)
- Date of Birth (day / month / year)
- Family Status (single / married / divorced / other) if dependents are to be insured
- Number of dependent children (estimate if necessary)
- Name (family name, first name)
- Nationality
- Country of Residence (where the family lives)

If available:

- Commencement Date of Employment (day / month / year)
- Job Title or Job Description
- Country of Assignment (workplace location)