

Overseas Travel Insurance Services, LLC

A+ Long Term Group Application (2005)

PLEASE PRINT OR TYPE ALL SECTIONS

Name of Group:	Type of Business:	Telephone: Fax:
Street Address:	City:	State:
Country:	Postal Code:	Contact Person:

<p>Does Group presently have group medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please attach the following:</p> <ol style="list-style-type: none"> 1. Copy of policy or booklet describing benefits. 2. Copy of most recent billing statement. 3. Copy of most recent 3 years claims experience.

Total number of employees: <small>(including US based & international employees)</small>	Total number of Eligible employees: <small>(international employees only)</small>
<p>Are any Eligible employees presently residing in the US or Canada? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please provide the following information:</p>	
Employee _____	Expected Date of Departure: _____
Employee _____	Expected Date of Departure: _____
Employee _____	Expected Date of Departure: _____
<p>Are any Eligible employees presently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please provide the following information:</p>	
Employee _____	Date/Nature of Qualifying Event: _____
Employee _____	Date/Nature of Qualifying Event: _____
Employee _____	Date/Nature of Qualifying Event: _____

Benefit Options Desired:	
Deductible	<input type="checkbox"/> \$150 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500
Maximum Benefit	<input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$5,000,000
Prescription Drug Card	<input type="checkbox"/> Yes <input type="checkbox"/> No
Waiting Period – New Employees	<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> other:
<p>Please answer the following questions to the best of your knowledge. For Yes answers, provide additional details in the space provided.</p>	
1. Has any employee or dependent suffered from a	<input type="checkbox"/> Yes <input type="checkbox"/> No

condition which resulted in a claim of \$5,000 or more during the last 3 years?		
2. Are any employees or dependents currently pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are any employees or dependents currently hospitalized, confined at home, disabled or incapacitated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are any employees not actively at work performing normal duties due to illness or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Are you aware of any circumstances or conditions which can be expected to produce an ongoing claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional Comments: (attach additional sheets if necessary)		

Employee Census: List each eligible employee, spouse and dependent child. Initial quotation will be based on this census. Final rates will be determined based on actual enrollment. (Attach additional sheets if necessary.)					
Name	Sex	Status *	Date of Birth	Annual Salary	Country
*Status: E=Employee Only ES=Employee and Spouse Only ECH=Employee and Child(ren) Only F=Employee and Spouse and Child(ren)					

Name of Agent: LeAnne Lary	Company: Overseas Travel Insurance Services, LLC	Agent Number: 22595
This information is intended to provide us with information necessary to provide you with coverage and premium indications. Final rates and coverage will be based on the actual enrollment. No insurance is in effect until you are notified in writing.		
Signature: (Authorized representative of group)	Printed Name:	Date:

Please send or fax to the following:
 Overseas Travel Insurance Services, LLC
 2165 Calle Riscoso Thousand Oaks, CA 91362
 Phone: 866-684-7123 or 805-531-9200 Fax: 805-531-1161