

# Short Term (3 yrs or less) Overseas Travel Medical Insurance Group Quote Request

All group programs require a minimum of 5 primary insureds and a \$1000 minimum deposit premium. Group programs may be modified to suit the group's needs. If you are in need of benefits and/or provisions that are not specifically addressed on this form, contact **Overseas Travel Insurance Services, LLC** for assistance in obtaining those benefits and/or provisions.

Additionally, if your group currently has international medical coverage through another carrier or has been covered for international benefits at some time in the past 12 months, please provide the name of the carrier, claims and premium experience for the coverage periods, current census, premiums and benefit plan.

**Please Print or Type**

## Part A: Administrative Information

Group Name:	
Address:	
City:	State/Province:
Postal Code:	Country:
Contact:	Title:
Phone:	Fax:
Nature of Group:	

## Part B: Coverage Information

Country(ies) to be visited:			
Purpose of trip and/or coverage:			
Will coverage be worldwide? (ie. coverage in home country) <input type="checkbox"/> Yes <input type="checkbox"/> No    Please explain:			
Period of coverage: From:		To:	
Average length of stay per participant:			
Average Age of Participants:			
Number of Trips per Year:			
Number of Participants:	Singles:	Single + 1:	Families:
Is coverage mandatory for all participants? <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, please explain:			
Premium Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily (Note: All premium must be submitted in advance, prior to group departure, unless billing arrangements have been made with SRI.)			

**Part C: Benefit Options**

Medical Benefit Limit Options:  \$10,000  \$15,000  \$25,000  \$50,000  \$100,000  
Select Only Two (2) Options  \$250,000  \$500,000  \$1,000,000  
Per Person Per Coverage Period

Deductible Options:  \$0  \$25  \$50  \$100  \$250  \$500  \$1000  
Select Only Two (2) Options  \$2500  
 Per Policy Period Deductible or  Per Incident Deductible

Coinsurance Options:  80/20% of the next \$5,000 of Eligible Expenses after the  
Select Only One (1) Option Deductible  
 100% after the Deductible

Emergency Evacuation Options:  None  \$25,000  \$50,000  \$100,000

Repatriation of Mortal Remains:  None  \$10,000  \$20,000

AD&D Principal Sum Options:  None  \$5,000  \$10,000  \$15,000  \$20,000  
 \$25,000  \$50,000

Coverage Options:  Hazardous Sports Coverage  
 Home Country Coverage (# of Home Country Days not to Exceed 60 days per 12 months of Coverage)

**Part D: Agent Information**

SRI Agent# 1009 Agent Name: \_\_\_\_\_  
Company Name: Overseas Travel Insurance Services, LLC  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Part E: Additional Information**

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Please be certain to complete this form in full and fax to Overseas Travel Insurance Services, LLC Upon receipt, we will send an official Proposal to you within 24-48 hours (Weekends and Holidays excluded). Please Fax Request to:

**Overseas Travel Insurance Services LLC (OTIS)**

Fax: 805-531-1161 or Phone: 805-531-9200 or In US 866-684-7123

Web site: [www.otis123.com](http://www.otis123.com) or e-mail: info@otis123.com