Group Plan

MediCare INTERNATIONAL

Broker's stamp

Return completed form to your Financial Advisor or Broker or to:
MediCare International
One Hundred Whitechapel
London E1 1JG, England
Telephone: +44 (0)20 7816 2033
Facsimile: +44 (0)20 7816 2188
E-mail: medicare@medicare.co.uk
Website: www.medicare.co.uk

Group Employer Quotation Questionnaire

PLEASE COMPLETE IN BLOCK CAPITALS AND TICK RELEVANT BOXES

Your company details

Company name:

Type of business:

Address:

Postcode:

Country:

Contact name:

Telephone:

Facsimile:

Email:

Position in company:

1. Eligibility/premium payment

a. How many people does the company employ? ☐

b. Will the insurance apply to all employees? ☐Yes ☐ No
If NO, please define precisely the class/es of employees to which the cover will apply:

c. Are the employees' dependants to be covered? ☐Yes ☐ No
Will the company be paying the premium for:
Employees only ☐Yes ☐ No
Employees & dependants ☐Yes ☐ No
Other – please specify:

2. Previous claims experience

a. Are you or have you previously been insured for medical benefits? ☐Yes ☐ No
If YES, please give name/s of previous insurers here and attach previous benefit and renewal date details:

b. Please provide the following information:

Year	Total Membership Covered	Premium Paid	Number of Claims	Amount of Claims	Amount of Claims Outstanding

c. Please provide separate details of any claims which individually exceed £10,000:

Year	Total Membership Covered	Premium Paid	Number of Claims	Amount of Claims	Amount of Claims Outstanding

3. Age/status breakdown of persons to be included

Please provide the following information:

Age	Number of employees requiring cover		
	Single Cover	Married Cover	Family Cover*
Child			
18-25			
26-29			
30-34			
35-39			
Total			

Age	Number of employees requiring cover		
	Single Cover	Married Cover	Family Cover*
40-44			
45-49			
50-54			
55-59			
60-64			
Total			

* Family cover will include cover for the employee, spouse and children up to age 18, or 24 if they are in full-time education.

4. Geographical spread of risk

Please provide the following nationality and geographical information:

NB. USA, Canadian and Caribbean nationals resident in their home country are not eligible for cover. Please indicate if the details above include any such persons.

Number of Employees	Nationality	Location

Number of Dependants	Nationality	Location

5. Range of cover required

Please indicate the benefit range required:

Option a.
☐ **International Plan**

Option b.
☐ **International Plus Plan**
☐ With £100 excess payable
OR
☐ No excess payable*

Option c.
☐ **Executive International Plan**
☐ With £100 excess payable
OR
☐ No excess payable*

Option d.
☐ **Bespoke Plan**
(only available for 50 or more employees)

*Please choose ONE option only

	If a bespoke scheme is required, please indicate the benefits to be included	Limit required	Deductible or co-insurance Per Claim
H	Hospital Services		
	Parental Accommodation		
£	Hospital Cash Benefit (maximum of 30 days)	£250 per night	
	Daycare Surgery		
	Local Road Ambulance Service		
	Emergency Medical Evacuation		
	Repatriation or Local Burial	£7,500 per person	
	Home Nursing (up to 180 days)		
	Accident and Emergency Room Services		
	Oncology, Chemotherapy and Radiotherapy		
	MRI and CT Scans		
	Organ Transplantation Surgery	£100,000 per year	
	Dental Treatment following Accident		
	Routine Dental Treatment	£500	20% co-insurance
	Rehabilitation Care	£100,000 lifetime limit	
	Newborn Care	£5,000	20% co-insurance
	Outpatient Services (Voluntary excess option applies to this benefit only)		
	Maternity Care Normal Pregnancy	Up to £5,000	20% co-insurance
	Complicated Pregnancy	Up to £10,000	20% co-insurance
W	Wellness Benefit	Up to £500	20% co-insurance
PA	Optional Personal Accident Cover	£50,000 per unit (maximum £250,000)	
M	Overall Annual Limit	£1,000,000	

If you wish to pay your premium in US dollars or euros please see our website (www.medicare.co.uk) or telephone: +44 (0)207 816 2033 for the current agreed exchange rate

Any other benefit required:

Premium frequency required:
☐ Annual ☐ Half Yearly
☐ Quarterly

If you have any queries while completing this form please call our Customer Service Helpline:
+44 (0)20 7816 2033
or you can email us at:
medicare@medicare.co.uk

Declaration

We request a Group Insurance quotation and declare that to the best of our knowledge and belief the information given herein is true and complete.

Name:

Signature of authorised official:

Date: