



QUALITY SERVICE TO THE COMMUNITY SINCE 1980 425 HUEHL RD, STE.22-A, NORTHBROOK, IL 60062 PH: 847-897-5120 / 800-344-9540. FAX: 847-897-5130

www.ciainsagency.com/missionary.htm

MP+INTERNATIONAL REQUEST FOR PROPOSAL

Mission Name	Telephone						
Street Address	Contact Person						
City	State	Country	Postal Code				
Desired Effective Date	_						
What is the employee and/or self-employed	filing status with the IR	IS?					
(Check all boxes that apply) 🔲 W-2 🔲 1099 🗎 No Compensation							
BENEFIT PLANS DESIRED	BENEFIT PLANS DESIRED						
HIPAA compliant for appointed representative representatives Yes \(\sigma\) \(\frac{1}{2}\)	-	employed receiving	1099), requires 80% of appointed				
Deductible Requested: ☐ \$100 ☐ \$	\$250	\$1000	\$2500 \$5000				
Lifetime Maximum \$1,000,000 \$	5,000,000						
Life Insurance \$25,000	50,000 Other	Amount					
Agency	Agent Name		Agent #				
Address	City	State_	Country				
Telephone	Fax		Email				
Does applicant presently have group medical insurance? Yes No If yes, please attach the following: 1. Copy of present policy and/or booklet describing benefits. 2. Copy of most recent billing statement from present carrier. 3. Copy of most recent 3 years claims experience. (In most instances, this can be obtained from your present and/or past carrier(s))							
Total number of full-time and part-time employees Total number of eligible employees & appointed representatives (including U.Sbased and international employees)							
Member Category (provide count) - 1. Employees, work more than 30 hours a week 2. Volunteers 3. Self-Employed							
Has another insurance carrier refused yo	ur group?]Yes □ No					
How many covered employees & appointed representatives have been employed less than six months?							
Do you expect the number of covered persons to vary by more than 10% during the next 12 months? \(\subseteq \text{ Yes} \subseteq \text{ No} \) If yes, please explain:							
Does your group offer COBRA?							
Name		Date Cobra	a began				
Name		Date Cobra	began				
Name		Date Cobra	a began				

Please answer the following questions to the best of your knowledge. If your answer to any of these questions is yes, please provide details in the space provided below.								
1.	To the best of your knowledge, has any person to be covered under this plan, including dependents suffered from a condition which resulted in a claim of \$2,500 or more during the last 3 years?							
2.	Is any person to be covered under this plan, i	ncluding dep	endents cu	rrently pregn	nant?	Yes	□No	
3.								
4.	Is any person to be covered under this plan, including dependents not actively at work performing his/her normal duties due to illness or injury?							
5.	Are you aware of any circumstances, chronic or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims?							
Additi	onal Comments: (attach additional shee	ets if neces	sary)					
Employee Census: It is important that each person to be covered be included on this census. The initial quotation is based on this census. Final rates are based on actual enrollment.								
Sex	Name	Pay Type*	Status**	Date of Birth	Hire Dat	e Annu Sala		
		7,7						
Provide	e names of any U.S. Veterans:							
*Pay Type: Employee (E) Volunteer, Self-Employed Contractors or other Non-Compensated Mission Affiliates (V) **Status: Primary Insured (E) Spouse (S) Dependent Child (D)								
The information provided on this form, including attachments, is intended to provide the company with information necessary to evaluate your group and provide you with premium and coverage indications. Final rates and coverage will be based on the actual enrollment, including evidence of insurability, if applicable. No insurance is in effect unless you are notified in writing by the company. Thank you for your interest in Mission+Plus International.								
Applicant Signature								
Agent Signature DateUodated 07/03								



Ramesh Patel & Ishani Shah Marketing Directors 425 HUEHL RD, STE.22-A, NORTHBROOK, IL 60062

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