Group Medical Travel Insurance Application

(EMPLOYER VERSION)

Proposed Effective Date:______

Employer Group Name: ______
FEIN _____
Address (Street, City, State, Zip): ______
______ (If more than one location, please attach a list of location addresses separately.)

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1. Will you be using a travel facilitator to arrange all overseas medical travel? ☐ Yes ☐ No

If yes, please provide the name of the facilitating organization. ______

If no, please explain: ______

2. What is the nature of the operations of the employer? (i.e.- description of business) ______

3. Who is the carrier for your group health insurance? If self funded, please list the administrator's information. ______

4. Please provide the group health insurance policy or plan number and a copy of most your most recent census. If census is available electronically, provide access options.

5. How many covered members in your group health plan are eligible for the overseas medical option? ______

6. Is the member's overseas medical treatment mandatory or optional?
   ☐ Mandatory ☐ Optional ☐ Incentive Driven

   If incentive driven, please provide details. ______

7. What procedures are approved for employees at overseas facilities? If there is not an approved list of procedures, please explain the process for approval of an employee to go overseas for a medical treatment.

   _____

8. Are the facilities that are approved JCI Accredited? ☐ Yes ☐ No

9. Do you want to include all international travel (business and leisure travel), not only travel for overseas medical procedures?
   ☐ Yes ☐ No If yes, please answer the below questions. If no, skip to #8.

   How many employees regularly travel overseas for business per year?______

   Estimated number of business travel days for all employees per year? _____

10. Please choose which Capital Sum limits you would like your group members to have.

☐ **$50,000** ☐ **$100,000** ☐ **$150,000** ☐ **$200,000** ☐ **$250,000**

***Please note: Per member per month (PMPM) participation fee will vary based on which capital sum is chosen. An increase in utilization could affect the rate with a 30 day written notice.**

Provide additional details here along with any remarks or questions:

CUSTOM ASSURANCE PLACEMENTS, LTD.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSUARNCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORAMTION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRADULANT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND (NY: SUBSTANTIAL) CIVIL PENALTIES. (Not Applicable in CO, HI, NE, OH, OK, or VT; in DC, LA, ME, TN and VA Insurance benefits may also be denied).

Insured's Signature: ______________________________ Dated: ____________________

Please note that the participation fee for this insurance will be changed on a per employee per month basis. We will charge monthly using your group billing and send an invoice to be paid.

INSURANCE IS NOT IN EFFECT UNTIL THIS APPLICATION IS RECEIVED AND CONFIRMATION IS PROVIDED.

Complete and submit to:

Custom Assurance Placements, Ltd

Mailing Address: P.O. Box 5736, Columbia, South Carolina 29250-5736 USA

Phone: +1 (803)799-1770 • Fax +1 (803)799-1817 • www.customassurance.com

Or via email to tsimons@customassurance.com