

***Group Medical Travel Insurance Application
(FACILITATOR VERSION)***

Proposed Effective Date: _____

Applicant Name: _____

Physical Address (Street, City, State, Zip): _____

SECTION I

1. Number of international Medical Travelers you facilitate annually? _____
2. Countries of origin of international patients. If you accept patients from any country, please provide a breakdown of number by country for countries with the most activity.
Please complete on the attached spreadsheet
3. Please provide the number of procedures in each category performed each year per the attached list. If there are some that are not included in the attached list, please list them separately?
Please complete on the attached spreadsheet
4. Are all the hospitals/facilities you send patients to JCI Accredited? Yes No
If No, please advise if the facilities have any other type of accreditation. Provide details: _____
You can attach a separate list, if needed.
5. Please provide loss history of any current or prior coverage, if applicable.
6. Please advise of any current or prior situations that may have given rise to a claim under this or any similar policy.
7. Any known mortality for a patient you facilitated in the past? If yes, please provide details.
8. Will you be requiring medical travel accident (GPS) coverage for 100% of all eligible international medical travelers and on all eligible procedures? Yes No

If not, please provide details of the patients you would like be including in the coverage?
(i.e. procedure types, age groups, geographical locations)

SECTION II

1. What is the minimum and maximum age allowable for international patients? _____
Please note, special exceptions may be required to accept international medical travelers under age 18 and over age 70.

2. Do you require all medical travelers to have a home country physician provide a medical release to travel?
 Yes No

If yes, please attach a sample of the document you use.

Do you keep this information in the traveler's medical file? Yes No

If no, please describe any other safeguards in place to insure the medical traveler is fit to travel. _____

3. Are medical travelers screened for co-morbidity issues prior to approval for a procedure at an international facility?

4. Please attach blank copies of your application documents required for international medical travelers.

5. Does every international medical traveler leave the facility that performed the procedure/care with a copy of their medical records?

Yes No

If yes, are records provided in English? Yes No

If no please describe how records are provided: _____

Note, a copy of medical records in English may be required to adjust a claim.

Please choose which Principal/Capital Sum limits you would like quoted.

\$50,000 \$100,000 \$150,000 \$200,000 \$250,000

CUSTOM ASSURANCE PLACEMENTS, LTD.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULANT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES WHERE APPLICABLE AND/OR MAY RESULT IN A DECLINATION OF COVERAGE.

Authorized Signature: _____ Print Name: _____

Title: _____ Date: _____

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

Complete and submit to:
Custom Assurance
PLACEMENTS, LTD.
A SPECIALTY LINES INSURANCE BROKER

Post Office Box 5736 Columbia, South Carolina 29250-5736 USA
www.globalprotectivesolutions.com | www.customassurance.com
Telephone: +1 803.799.1770 | Facsimile +1 803.799.1817