Overseas Travel Insurance Services, LLC

A+ Long Term Group Application (2005)

PLEASE PRINT OR TYPE ALL SECTIONS

Name of Group:	Type of Business:		Telephone: Fax:
Street Address:		City:	State:
Country:	Postal Code:	Contact Person:	

Does Group presently have group medical coverage? □ Yes □ No
If yes, please attach the following:
1. **Copy of policy or booklet describing benefits.**
2. **Copy of most recent billing statement.**
3. **Copy of most recent 3 years claims experience.**

Total number of employees: (including US based & international employees)	**Total number of Eligible employees:** (international employees only)

Are any Eligible employees presently residing in the US or Canada? □ Yes □ No
If Yes, please provide the following information:

Employee______________________________ Expected Date of Departure:________
Employee______________________________ Expected Date of Departure:________
Employee______________________________ Expected Date of Departure:________

Are any Eligible employees presently on COBRA? □ Yes □ No
If Yes, please provide the following information:

Employee____________________________ Date/Nature of Qualifying Event:________
Employee____________________________ Date/Nature of Qualifying Event:________
Employee____________________________ Date/Nature of Qualifying Event:________

Benefit Options Desired:		
Deductible	□ $150 □ $250 □ $500 □ $1,000 □ $2,500	
Maximum Benefit	□ $1,000,000 □ $5,000,000	
Prescription Drug Card	□ Yes □ No	
Waiting Period – New Employees	□ 30 days □ 60 days □ 90 days □ other:	

Please answer the following questions to the best of your knowledge. For Yes answers, provide additional details in the space provided.

1. Has any employee or dependent suffered from a	□ Yes	□ No

condition which resulted in a claim of $5,000 or more during the last 3 years?		
2. Are any employees or dependents currently pregnant?	☐ **Yes**	☐ **No**
3. Are any employees or dependents currently hospitalized, confined at home, disabled or incapacitated?	☐ **Yes**	☐ **No**
4. Are any employees not actively at work performing normal duties due to illness or injury?	☐ **Yes**	☐ **No**
5. Are you aware of any circumstances or conditions which can be expected to produce an ongoing claim?	☐ **Yes**	☐ **No**
Additional Comments: (attach additional sheets if necessary)		

Employee Census: List each eligible employee, spouse and dependent child. Initial quotation will be based on this census. Final rates will be determined based on actual enrollment. (Attach additional sheets if necessary.)

Name	Sex	Status *	Date of Birth	Annual Salary	Country

***Status: E=Employee Only ES=Employee and Spouse Only ECH=Employee and Child(ren) Only F=Employee and Spouse and Child(ren)**

Name of Agent:	Company:	Agent Number:
LeAnne Lary	**Overseas Travel Insurance Services, LLC**	**22595**

This information is intended to provide us with information necessary to provide you with coverage and premium indications. Final rates and coverage will be based on the actual enrollment. No insurance is in effect until you are notified in writing.

Signature:	Printed Name:
(Authorized representative of group)	**Date:**

Please send or fax to the following:

Overseas Travel Insurance Services, LLC

2165 Calle Riscoso Thousand Oaks, CA 91362

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