QUOTATION FORM: GROUPS

CORPORATE SCHEMES FOR OVER 100 ADULTS

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Please complete this form in English and BLOCK CAPITALS.
This form is for specially underwritten health insurance policies.

1. GENERAL DETAILS

Company / Employer name: _____

Nature of business: _____

Scheme administrator name: _____ Email: _____

Phone no: _____ Mobile no: _____ Fax no: _____

Correspondence address: _____

_____ Desired policy inception date: | | | | | | | | |

2. ELIGIBILITY

Company size: _____employees This insurance will apply to: ○All employees ○Some employees only

If 'some employees only' state which class/es of employees (e.g. office, blue collar, etc.): _____

3. GROUP PROFILE

Total no. of employees: _____ Total no. of spouses: _____

Total no. of children*: _____ Total group membership: _____

Scheme enrolment will be: ○Compulsory ○Voluntary Company share of premium: _____%

4. SCHEME MEMBER BREAKDOWN

Age	No. of Employees		No. of Spouses		No. of Children*	
	Male	Female	Male	Female	Male	Female
0 - 17						
18 - 25						
26 - 29						
30 - 34						
35 - 39						
40 - 44						
45 - 49						
50 - 54						
55 - 59						
60 - 64						
65 - 69						
TOTAL						

*Children must be under 18 years old, or under 24 years old if in full-time education

If the Group is transferring from another scheme please complete questions 5 & 6.

5. PAST PREMIUM (please state years the group was insured in the first column)

Year	No. of Insureds			Premium (£)
	Male	Female	Child	
2014 - 2015				
2015 - 2016				
2016 - 2017				
TOTAL				

6. CLAIMS INFORMATION

Claims Details	2014 - 2015		2015 - 2016		2016 - 2017	
	No. of claims	Claims total (£)	No. of claims	Claims total (£)	No. of claims	Claims total (£)
In-patient						
Out-patient						
TOTAL						

Please list individual claims over £3,000 separately, with details.

6. BENEFITS

Benefit	Please tick ✓	Benefits	Please tick ✓
Hospital Services (Room & Board, In- and Day-Patient Treatment)		Hospice & Palliative Care	
Parent Accommodation		Rehabilitration Treatment	
External Prosthetic Devices		Medical Aids (wheelchairs, knee braces or crutches)	
Out-Patient Services		Accident & Emergency Services	
Acupuncture & Specialist Herbal Treatment		Innocent Bystander in Terrorist Incident	
HIV & AIDS (Max 6 years)		Compassionate Home Visit	
Local Ambulance Services		Organ Transplant (heart, lung, kidney, liver or bone marrow)	
Nursing at Home		Complications of Childbirth	
Emergency Medical Evacuation		Routine Maternity Care & Childbirth	
Emergency Dental Treatment following an accident		Repatriation or Local Burial/Cremation	

7. DEDUCTIBLE

Deductibles apply per ailment claim per policy year. Please select your desired deductible amount:

Out-Patient: ○ £100 ○ £150 ○ £500

In-Patient: ○ None ○ £250 ○ £500 ○ £1,000 ○ £5,000

8. COUNTRIES OF RESIDENCE & NATIONALITIES

Country of Residence	No. of Employees

Nationality	No. of Employees

9. ADDITIONAL REQUIREMENTS

10. SIGN AND RETURN QUOTATION FORM

This section should be signed by the Scheme Administrator, who is an Authorised Person who can apply on behalf of the Employer and all persons to be insured, and does so with their full consent.

Scheme Administrator Name: _____ Position: _____

Scheme Administrator Signature: _____ Date: | | | | | | | | |