



instructions

- Please Print or Type

part a » general group information

Form with fields for Group Applicant/ Company Name, Group Email Address, Address, City, State, Zip Code, Country, Contact Name, Email Address, Telephone, Fax, Nature of Business, Requested Effective Date.

part b » group eligibility

Form with sections for Eligible Employees, coverage options, employee profile breakdown, and a detailed table for employee demographics by age and gender.



part c » benefits requested

Requested Benefit Schedule:			
<input type="checkbox"/> RESIDE Prime Worldwide	<input type="checkbox"/> RESIDE Worldwide	<input type="checkbox"/> Custom Plan <i>(Provide Details Below)</i>	<input type="checkbox"/> To Follow Expiring Plan <i>(Attach present Policy Wording describing Benefits)</i>
Desired deductible per insured person per policy period:			
<input type="checkbox"/> \$100	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000
<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000
<input type="checkbox"/> Other \$			
Desired Underwriting Method:			
<input type="checkbox"/> Individual Underwriting			
<input type="checkbox"/> "12/12" Pre-Ex Clause (Pre-Existing Conditions will not be paid during the first 12 months of this plan.)			
<input type="checkbox"/> Full Take-Over Provision (<i>i.e. No Loss/No Gain. For Take-Over Provision, we must receive the detailed claims experience listed below in order to provide a Binding Quote.</i>)			
Does the employer group presently have domestic and/or international group medical coverage?			
Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please attach the following:			
1. Present policy wording describing benefits.			
2. Most recent billing statement from present carrier.			
3. Copy of claims experience during the last three years, which include claims incurred, claims paid, and claims outstanding.			
4. Policy Period Dates for all of the above.			
Additional information / modifications to requested benefit schedule:			

part d » agent information

Agent Name:		Seven Corners, Inc. Agent#:	
Company Name:			
Address:		Email:	
City:	State:	Zip:	Country:
Telephone:		Fax:	

Please be certain to complete this form in full and mail or fax to Seven Corners, Inc.

Please Mail or Fax Request to:

Seven Corners, Inc.

303 Congressional Boulevard, Carmel, IN 46032

Phone: 800-335-0611 Fax: 317-575-2870



Worldwide Major Medical Group Proposal Warranted Statement

Assured Group:

Please answer the questions below. Also, be certain to review the proposal and contact Seven Corners, Inc. or your insurance agent with questions or modifications regarding the proposed benefits and terms.

Table with 11 rows of questions and Yes/No checkboxes, plus an additional comments section.

I am hereby duly authorized by the Assured Group to submit and apply for the Group program and for the insurance provided. I represent that I have read the completed application and that all my answers and statements on this Application and any attachments hereto is complete and true to the best of my knowledge and belief.

Name: _____ (Please Print or Type)

Signature: _____ Date: _____

Title: _____

THE INDICATION PRESENTED IN THIS PROPOSAL IS BASED UPON THE INFORMATION PROVIDED AND IS ONLY A RATE CALCULATION. IT IS NOT BINDING IN ANY WAY. FINAL RATES WILL BE DETERMINED BY ACTUAL ENROLLMENT AND UNDERWRITING.



Explanation page for Questions 1 thru 11:

[Empty rectangular box for providing an explanation for Questions 1 through 11.]