Reside Blue Group Quote Request Form

reside blue group
marine medical coverage

SECTION 1. GENERAL GROUP INFO

NAME OF VESSEL	CONTACT NAME	VESSEL REGISTRATION / FLAG
ADDRESS		
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

** Please attach a complete group census with submission of this form. Seven Corners can provide a census form if needed.**

SECTION 2. BENEFITS

DESIRED DEDUCTIBLE PER INSURED PERSON PER POLICY PERIOD (Please choose up to 3 options.) ☐ $0 ☐ $100 ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 Other $_____	DESIRED UNDERWRITING METHOD ☐ Individual Underwriting ☐ 12/12 ☐ Full Take-Over Provision
AD&D PRINCIPAL SUM OPTION (Please choose one option.) ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $500,000	TOTAL NUMBER OF EMPLOYEES _____ NUMBER APPLYING FOR COVERAGE _____
MATERNITY (Please choose one option.) ☐ Yes ☐ No	CONTINUATION OF COVERAGE OPTION ☐ Yes ☐ No
DOES THE EMPLOYER GROUP PRESENTLY HAVE INTERNATIONAL GROUP MEDICAL COVERAGE? ☐ YES OR ☐ NO	
TOTAL TIME VESSEL IS OUTSIDE THE US/CANADIAN WATERS _____ Months	REQUESTED EFFECTIVE DATE _____

SECTION 3. UNDERWRITING AND CLAIMS DATA

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE FOR ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS TO BE INSURED. GIVE DETAILS TO QUESTIONS ANSWERED "YES" IN THE SPACE PROVIDED BELOW OR ATTACH ADDITIONAL SHEETS, IF NECESSARY.

1) Has anyone been treated for serious illness, been hospitalized or had surgery in the past three years (i.e. cancer, juvenile diabetes, cardiovascular disease, AIDS, substance abuse, renal disease, mental illness)?	☐ YES ☐ NO
2) Has anyone undergone open-heart surgery or received significant cardiac testing at anytime in the past 3 years?	☐ YES ☐ NO
3) Has anyone had a claim of $2,500 or more in the past three years?	☐ YES ☐ NO
4) Is anyone apt to have a continuing claim from an existing mental or physical disorder?	☐ YES ☐ NO
5) Has anyone been advised to have surgery or diagnostic testing in the last 6 months or anticipate hospitalization for any other reason?	☐ YES ☐ NO
6) Are any employees or dependents currently pregnant?	☐ YES ☐ NO
7) Has any employee missed ten or more consecutive days of work in the past 12 months due to illness or injury?	☐ YES ☐ NO
8) Are there any spouses or dependents that are presently hospitalized, confined at home or treatment facility, disabled, or incapacitated?	☐ YES ☐ NO
9) Are there any employees who are not actively at work performing his/her duties full time due to illness or injury?	☐ YES ☐ NO
10) Are you ware of any circumstances, chronic or continuing medical, mental or nervous conditions, which can be expected to produce ongoing claims?	☐ YES ☐ NO

ADDITIONAL COMMENTS AND EXPLANATIONS FOR QUESTIONS 1-10 ABOVE, PLEASE ATTACH ADDITIONAL SHEETS.

I am hereby duly authorized by the Group Applicant listed in Section 1 of this application to submit and apply for the Group program and for the insurance provided by Certain Underwriters at Lloyds, London. 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. I understand that qualification for insurance is based upon my answers and statements herein and that Seven Corners, Inc. may verify this information. I understand that no one has the authority to exclude or direct me to exclude any information sought by this form. I understand that Seven Corners, Inc. will rely on all information on this Application in determining whether or not to issue Group coverage and that any incorrect or incomplete information may result in a claim denial or loss of coverage.

The quotation presented in this proposal is based up on the information provided and is only a rate calculation. It is not binding in any way. Final rates will be determined by actual enrollment. Coverage is subject to verification of census, first month's premium in advance and any other reasonable information requested by Seven Corners, Inc. No insurance shall be effective until Seven Corners, Inc. notifies the Group in writing.

Group Representative Signature_____

Printed Name_____ Title_____
Date_____

SECTION 4. AGENT INFORMATION

SEVEN CORNERS, INC. AGENT# 8292	AGENT NAME / COMPANY NAME Anita Warwick | Seven Seas Health, Inc	
ADDRESS 625 SW. 19th Street		
CITY Ft. Lauderdale	STATE Florida	ZIP CODE 33315
EMAIL anita@sevenseashealth.com		
PHONE (954) 763-9787	FAX (954) 665-2840	

AGENT CERTIFICATION: I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this application nor any supplement to the application. I have not advised the Applicant to withhold any information regarding the answers to the questions and have advised the Applicant to review the application and the answers recorded to confirm completeness and accuracy.

Agent Signature_____ Date_____

Please be certain to complete this form in full and attach any additional information. Please mail or fax to:
Seven Corners, Inc.
303 Congressional Blvd. / Carmel, IN 46032
Phone: 317-575-2652 ext.3377 / Fax: 317-575-2659