



ATLAS CORPORATE TRAVEL REQUEST FOR PROPOSAL

Omitted information may cause delay in the preparation of a proposal for the Group.

Name of Company:		Telephone:	
Street Address:		City:	State:
Country:	Postal Code:	Contact Person:	
Website Address:		Email:	

TRAVEL / EMPLOYEE INFORMATION:

<i>Provide an employee count by gender/age for each of the following scenarios:</i>	<i>Males between the ages of:</i>					<i>Females between the ages of:</i>				
	18-29	30-39	40-49	50-59	60-65	18-29	30-39	40-49	50-59	60-65
Estimated number of US based employees to travel abroad:										
Estimated number of Non-US based employees to travel abroad (excluding the US or Canada):										
Estimated number of Non-US based employees to travel inside the US or Canada:										

BENEFIT OPTIONS DESIRED:

Desired Number of Travel Days (min. 100 days):	
Desired Effective Date (1 st of the month) mm/dd/yy:	/ 01 /

Deductible:	<input type="checkbox"/> \$0 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500
Maximum Benefit:	<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000
Hazardous Sports Rider:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acute Onset of a Pre-Existing Condition for non-US Citizens (coverage is included for US citizens):	<input type="checkbox"/> Yes <input type="checkbox"/> No

ADDITIONAL COMMENTS:

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HCCMIS's privacy policy may be found at www.hccmis.com , or by contacting HCCMIS for a copy.

Producer Name:	Company:	Producer Number:
This form is intended to provide HCC Medical Insurance Services with information necessary to provide you with competitive rates for medical coverage. No insurance is in effect until you are notified in writing. Thank you for your interest in the Atlas Corporate Travel plan.		
Signature: (Authorized representative of group)		Printed Name: Date: