ALLIANZ CARE & HEALTH
GROUP QUOTATION REQUEST FORM

Please fill in this form and enclose a copy of census data. Provide one form per staff category.

SENDER / INTERMEDIARY

First Name: ..... Last name:..... Date of request:..... Tel:..... Fax: .....

DETAILS OF THE COMPANY

Company: ..... Number of Staff Categories: ..... Type of Staff category for this request (ex: all staff, senior management): .....

Address of the company: ..... Full name of signatory:..... Tel:..... Fax: .....

Email ..... Number of Employees: ..... Number of Spouses: .....Number of Children:..... Average age of employees: .....

Information required for Life Insurance: Staff category occupation: ....Staff category average annual salary: ....

COVER REQUESTED

	Primary	Vitality	Prestige
Maximum annual limits	❑ US$ 25,000 ❑ US$ 50,000 ❑ US$ 200,000 ❑ US$ 300,000 ❑ US$ 500,000 ❑ US$ 4,500,000	❑ US$ 25,000 ❑ US$ 50,000 ❑ US$ 200,000 ❑ US$ 300,000 ❑ US$ 500,000 ❑ US$ 4,500,000	❑ US$ 200,000 ❑ US$ 300,000 ❑ US$ 500,000 ❑ US$ 4,500,000
Level of reimbursement	❑100% ❑ 90% ❑ 80%	❑100% ❑ 90% ❑ 80%	❑100% ❑ 90% ❑ 80%

OPTIONS

Maternity	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Dental	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Vision	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Assistance	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

FREQUENCY OF PREMIUM PAYMENTS

❑ Annually ❑ Semi-annually ❑ Quarterly Effective date of coverage: ……../……. / …….

PLEASE, ENTER THE NUMBER OF EMPLOYEES PER AREA OF COVER:

	AREA OF RESIDENCE 1	AREA OF RESIDENCE 2	AREA OF RESIDENCE 3	AREA OF RESIDENCE 4	AREA OF RESIDENCE 5
AREA OF COVER 1 + OPTION USA					
AREA OF COVER 1					
AREA OF COVER 2					
AREA OF COVER 3					
AREA OF COVER 4					
AREA OF COVER 5					

PLEASE, NOTE THAT THE OCUNTRY OF RESIDENCE MUST BE INCLUDED IN THE AREA OF COVER

QUOTATION REQUEST - GROUP – GMCG 12926 – 003/2018