Quotation Request Form For Group Medical Insurance

Agent's / Broker's Name : Branch :

Name of Company :

Nature of Business :

Group Size : Employee Average Age :

Coverage Type :

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Employee & Family

Any other classes of insurance quoted by our company ? If YES, please provide the class of insurance, estimated premium and claim details (if any).

Class Of Insurance	Premium (RM)	Claim (RM)

Class Of Insurance	Premium (RM)	Claim (RM)

☐ **Group Hospitalization & Surgical (GHS) :-**

1. Are you currently been covered under any Group Medical / Hospitalization and Surgical Insurance Policy? If YES, please provide a copy of the benefits schedule and the following details :

Name of Insurer : Period of Insurance :

Plan :

☐ Full Reimbursement - Guaranteed Admission (Medical Card) ☐ Inner Limit - Guaranteed Admission (Medical Card)

☐ Full Reimbursement - Reimbursement ☐ Inner Limit - Reimbursement

2. Is the existing policy extended to cover employee's spouse and children? ☐ Yes ☐ No

3. Has there been any claims made and if so, how much and how many claims were made for each year for the last 3 years? If there is no Medical Insurance, please indicate Hospitalization Medical Expenses for the last 3 years. Please provide detailed breakdown of claims/medical expenses,(I.e claimant, admission date, diagnosis, claim amount)

Year	No of Employee	Policy Premium	Claims / Expenses Amount (RM)	No of Claims / Cases
Total				

Note :Please advise current year claim is recorded as of which month. _____

4. Is there any special provision or exclusion imposed on any employee or insured person in the existing policy? If YES, please attach policy schedule/ endorsement.

☐ **Group Outpatient Clinical (GOPC) (Optional, complete this only if this coverage is requested) :**

1. Has there been any claims made and if so, how much and how many claims were made for each year for the last 3 years? If there is no Medical Insurance, please indicate Outpatient Medical Expenses for the last 3 years. (We may require detailed breakdown of claims / medical expenses)

Year	No of Employee	No of Spouse	No of Children	Policy Premium	Claim Expenses (RM)			No of Claim / Cases		
					General Practitioner	Specialist Practitioner	TOTAL	General Practitioner	Specialist Practitioner	TOTAL

2. Is Long Term Care covered under the existing policy or company benefit? ☐ Yes ☐ No

Additional Remarks:

_____

_____

_____

Attended By : _____ Contact No : _____ Date : _____
(Full Name)

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