

# Reside Blue Group Quote Request Form



## 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.) <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 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> Other \$ _____	DESIRED UNDERWRITING METHOD <input type="checkbox"/> Individual Underwriting <input type="checkbox"/> 12/12 <input type="checkbox"/> Full Take-Over Provision	
AD&D PRINCIPAL SUM OPTION (Please choose one option.) <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$500,000	TOTAL NUMBER OF EMPLOYEES _____	NUMBER APPLYING FOR COVERAGE _____
MATERNITY (Please choose one option.) <input type="checkbox"/> Yes <input type="checkbox"/> No	CONTINUATION OF COVERAGE OPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	
DOES THE EMPLOYER GROUP PRESENTLY HAVE INTERNATIONAL GROUP MEDICAL COVERAGE? <input type="checkbox"/> YES OR <input type="checkbox"/> 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)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2) Has anyone undergone open-heart surgery or received significant cardiac testing at anytime in the past 3 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3) Has anyone had a claim of \$2,500 or more in the past three years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4) Is anyone apt to have a continuing claim from an existing mental or physical disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5) Has anyone been advised to have surgery or diagnostic testing in the last 6 months or anticipate hospitalization for any other reason?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6) Are any employees or dependents currently pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7) Has any employee missed ten or more consecutive days of work in the past 12 months due to illness or injury?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8) Are there any spouses or dependents that are presently hospitalized, confined at home or treatment facility, disabled, or incapacitated?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9) Are there any employees who are not actively at work performing his/her duties full time due to illness or injury?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10) Are you ware of any circumstances, chronic or continuing medical, mental or nervous conditions, which can be expected to produce ongoing claims?	<input type="checkbox"/> YES <input type="checkbox"/> 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# 3086	AGENT NAME / COMPANY NAME <b>Blue Water Yacht Insurance, Inc</b>
ADDRESS 1016 Clemons St.	
CITY Jupiter	STATE FL ZIP CODE 33477
EMAIL service@bluewaterins.com	
PHONE 800-866-8906	FAX 561-575-0418

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