Insurance Mass Marketing Systems, Inc.
A Division of The Heusinkveld Group

REQUEST FOR STOP LOSS BINDER

We hereby request Insurance Mass Marketing Systems, Inc. to bind coverage for:

GROUP NAME: _____
ADDRESS: _____
_____

TELEPHONE: _____ CONTACT: _____
TITLE: _____

GENERAL INFORMATION

Number of Employees:

	Single	Family	Total
Medical			
Dental			
Other			

Payment Mode:	Annual:	Monthly:	Other:

AGGREGATE STOP LOSS

Effective Date:_____ Carrier: _____

Coverage Basis: 12/12__ 15/12__ 14/12__ 24/12__ 12/15__ PD __ Aggregate Limit: _____

Annual Attachment Point:_____ ECC:_____

Annual Premium:_____ Monthly Factor:_____

Run - In Limit:____N/A_____ Premium Rate/EE:_____

AOP Limit:_____ Surplus Lines Rate:_____

Payment Mode: Annually_____Quarterly_____Monthly_____Other:_____
Plans to be included: Medical_____ Dental _____PCS Card ____ Vision _____WDI _____
Type: New_____ Renewal _____ Policy Term:_12 MONTHS_____

SPECIFIC STOP LOSS

Effective Date:_____ Carrier: _____

Coverage Basis: 12/12__ 15/12__ 14/12__ 24/12__ 12/15__ PD ___

Deductible:_____ Coverage Amount (in excess of deductible):_____

Premium Rates: Single:_____ Family: _____ Composite:_____

Surplus Lines Rate: _____ _____ _____

Total Rate: _____ _____ _____

Payment Mode: Annually_____ Quarterly_____ Monthly _____Other_____

Plans to be included: Medical_____Other_____ Type: New____ Renewal____ Policy Term _____

Name of Third Party Administrator: _____

Signature:_____ Title: _____ Date:_____

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