

GHS QUOTATION REQUISITION FORM

(For Office Use Only)

To : Medical Insurance Department Attention: _____

From : _____

Tel : _____ Fax: _____

Broker/Agent: _____ Account No: _____ Branch : _____

Name of Company : _____

Business/ Trade : _____

Declared Group Size : Male: Female Total:

Previous Insurer (if available): _____

<i>Demographic Distribution of Group</i>						
<i>Number of Employees</i>	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
Age Band 18 to 35						
Age Band 36 to 45						
Age Band 46 to 55						
Age Band 56 to 60						
Age Band 61 to 66						
Total number of members:						

<i>Members Under Each Category</i>						
<i>Number of Employees</i>	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
Employee Only						
Employee & Spouse						
Employee & Children						
Employee & Family						
Total number of members:						

<i>Coverage</i>						
<i>Members Under Each Category</i>	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
Room & Board						
Basis (IL-Inner Limit; AC-As Charged)						
Annual Overall Limit						
Additional Benefit	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F

<i>Claim Statistics</i>				
Period	2 Years Ago	Last Year	Current Year	
Group Size				
Claim Amount				

Any Other Information

(If space is not sufficient, please include information by attachment)

Date: _____ Signature: _____