ACE MEDICAL INSURANCE LIMITED

CLIENT QUESTIONNAIRE

SUITE B903, THE OCTAGON, BARNES ROAD, ACCRA
TEL: 0556778903/0556778906/0556778907
E-MAIL: info@acemedinsurance.com
WEBSITE: www.acemedinsurance.com

NAME OF COMPANY:						
LOCATIONAL ADDRESS:						
POSTAL ADDRESS:						
E-MAIL ADDRESS:						
TEL. NO.:				FAX:		
TOTAL NO. OF OFFICES & LOCATIONS:						
TOTAL No. OF STAFF:		MALE:		FEMALE:		
AGE RANGE:		AVERAGE AGE:				
COVER FOR DEPENDENTS:	YES		NO			
TOTAL NO. OF DEP. TO BE COVERED IF YES:		SPOUSES:		CHILDREN:		
AGE LIMIT FOR CHILDREN:						
TYPE OF HEALTH PLAN SOUGHT:	TPA		INSURANCE			
BRIEFLY DESCRIBE THE NATURE OF YOUR WORK:						
HAVE YOU EVER PURCHASED HEALTH INSURANCE FOR YOUR EMPLOYEES?		YES		NO		
IF YES, PLEASE INDICATE PREMIUM PAID:						
Kindly provide a copy of the benefit plan if yes.						
IF NO, WHAT HEALTHCARE SYSTEM DID YOU HAVE IN PLACE?						
HOW MUCH DO YOU SPEND PER EMPLOYEE ON HEALTHCARE UNDER THIS SYSTEM?						

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