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Please return this questionnaire to reserve@providentins.com.

PO Box 11588 - 272 Alpha Drive - Pittsburgh, PA 15238
(800) 447-0360 - (412) 963-1200 - Fax (412) 963-0415 - providentins.com

# Emergency Service Organization New Business Underwriting Questionnaire

**Instructions:**

- In order to reserve a proposal for any Emergency Service Organization product, Sections 1 and 2 must be completed in full. This reservation will be good for 90 days from the date of submission or until the date proposals are needed, whichever is longer.
- Section 3 must be completed in full in order to receive a proposal for any policy type.
- In order to obtain an Accident & Health proposal, Sections 4a and 4b must also be completed in full.
- In order to obtain a proposal for other group products, please complete Section 5 and/or 6 and/or 7. Also, include a roster for Group Term Life and Group Critical Illness proposals.
- Please do not leave blanks. Use N/A or zero if necessary.

Once you have compiled all necessary information and completed this questionnaire, please email all documents to reserve@providentins.com. Thank you for your cooperation.

Date of New Business Submission: _____ Date Proposal(s) Needed: _____

Which policies would you like to propose?
- ☐ Accident & Health (A&H)
- ☐ Accidental Death & Dismemberment (AD&D)
- ☐ Group Term Life (GL)
- ☐ Group Critical Illness (GCI)

## Section 1: General Policyholder Information

Policyholder Name (as it should appear on a policy): _____

_____

Physical Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Mailing Address: (check if same as above) ☐ _____

City: _____ County: _____ State: _____ Zip Code: _____

Org. Phone: _____ Org. Fax: _____

Org. Website: _____

Org. Contact Person: _____ Contact Position: _____

Org. Contact Email: _____ Contact Phone: _____

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## Section 2: Broker Information

Agency Name: _____

Agency Mailing Address: _____

Agency City: _____ State: _____ Zip: _____

Agency Phone: _____

Agency Fax: _____

Agency Website: _____

Broker Name: _____

Broker Life, Accident & Health License #: _____

Broker Mobile Phone: _____

Broker Email: _____

CSR Name: _____

CSR Phone: _____

CSR Email: _____

## Section 3: Emergency Service Organization Information

Type of Organization: ☐ Fire District ☐ Independent Department ☐ Municipally Based
☐ Other (Describe: _____ )

Is the organization incorporated? ☐ Yes ☐ No

Is the organization a for-profit or not-for-profit organization? ☐ For-Profit ☐ Not-for-Profit

Type of Services Provided (check all that apply):

| | | |
|---|---|---|
| ☐ Fire | ☐ Search & Rescue | ☐ Relief Association |
| ☐ Rescue | ☐ Wildland Fire | ☐ County / State Association |
| ☐ Ambulance | ☐ Rope Rescue | ☐ Training School |
| ☐ First Responder | ☐ Water Rescue | ☐ 911 Emergency Dispatch |
| ☐ Haz Mat | ☐ Dive Rescue | ☐ Police |
| ☐ Hospital EMS | ☐ Ski Patrol | ☐ Other: _____ |

Population area served on a First Call basis: _____

Square mileage of First Call area: _____

First Call area is primarily: ☐ Rural ☐ Suburban ☐ Urban

Named Insureds: _____

_____

_____

If there are multiple entities covered by the policyholder, please include a list with the name and address of each entity.

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## Section 4a: Accident & Health Underwriting Information

Number of locations with emergency operations: _____

Do you operate an ambulance? ☐ Yes ☐ No

Annual Number of Runs: Fire and other non-medical runs: _____
Emergency medical or first responder medical: _____
Non-emergency transports: _____

Number of Vehicles:
Fire: _____ Rescue: _____ Ambulance: _____ Other: _____

Number of Volunteer and/or Paid-on-Call Members: _____
*Volunteers perform services without expectation of any compensation. Paid-on-call members collect nominal remuneration.*

Number of Part-Time Personnel: _____
*Part-Time personnel work less than 30 cumulative hours per week as emergency service providers for one or more organization(s) identified as a named insured of the policyholder.*

Number of Career Personnel: _____
*Career Personnel regularly work at least 30 cumulative hours per week as emergency service providers for one or more organization(s) identified as a named insured of the policyholder.*

Number of Trustees, Commissioners and/or Directors: _____

Number of Other Members: _____ Please describe: _____

Who do you want to cover? Check all that apply as defined above:
☐ Volunteers ☐ Part-Time ☐ Career
☐ Trustees, Commissioners, Directors ☐ Others

Who is covered by Workers' Compensation (WC)?

Volunteers: ☐ Yes ☐ No ☐ Not Applicable
What is covered?
☐ Disability ☐ Medical ☐ Both
Carrier Name: _____
Effective Date: _____

Career: ☐ Yes ☐ No ☐ Not Applicable
What is covered?
☐ Disability ☐ Medical ☐ Both
Carrier Name: _____
Effective Date: _____

Please list member/employee injury/illness claims suffered during the past three years:

Type and Amount Paid: _____

_____

_____

_____

Does the organization perform pre-membership medical screenings? ☐ Yes ☐ No

Does the organization perform annual medical evaluations meeting NFPA requirements? ☐ Yes ☐ No

Does the organization have a Safety Officer? ☐ Yes ☐ No

Does the organization provide EMS service beyond first aid? ☐ Yes ☐ No

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## Section 4b: Accident & Health Policy and Benefit Information

Current Insurance Carrier: _____ Current Premium: _____

Current Effective Date: _____ Current Pay Mode:

Please include Benefit Declaration Pages

- ☐ 1-year annual payment
- ☐ 3-year annual installment payment
- ☐ 3-year prepaid payment

Current A&H Benefit Limits

Injury Death Benefit: _____ Weekly Disability Limit: _____

Illness Death Benefit: _____ Disability Benefit Duration: _____

Medical Expense Limit: _____ Hospital Confinement Benefit: _____

Desired A&H Benefit Limits

| Death Benefit: ($5,000 - $500,000) | Weekly Disability: ($50 - $1,000) | Medical Expense: ($2,500 - $250,000) |
|---|---|---|
| Plan 1: _____ | Plan 1: _____ | Plan 1: _____ |
| Plan 2: _____ | Plan 2: _____ | Plan 2: _____ |
| Plan 3: _____ | Plan 3: _____ | Plan 3: _____ |

Does the organization participate in organized League Athletics? ☐ Yes ☐ No If yes, would the organization like organized league athletic coverage included in the proposal? ☐ Yes ☐ No

Type of sport: _____ Number of participants: _____

Start date: _____ Length of season: _____

| League Athletics | Death Benefit: | Accident Medical Expense: | Weekly Accident Indemnity: |
|---|---|---|---|
| ☐ Option 1 | $5,000 | $2,500 | $105 |
| ☐ Option 2 | $10,000 | $5,000 | $210 |

Additional Notes: _____

_____

_____

_____

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## Section 5: Accidental Death & Dismemberment

Current Carrier: _____ Current Policy Number: _____

Current Benefit Amount: _____ Desired Benefit Amount: _____

Current Effective Date: _____ Desired Effective Date: _____

Number of Members to be Covered: Volunteer: _____ Part-Time: _____ Career: _____

## Section 6: Group Term Life

Current Carrier: _____ Current Policy Number: _____

Current Benefit Amount: _____ Desired Benefit Amount: _____

Current Effective Date: _____ Desired Effective Date: _____

Number of Members to be Covered: Volunteer: _____ Part-Time: _____ Career: _____

Age Reduction Schedule: ☐ No Age Reduction
☐ Standard Age Reduction (50% at age 70)
☐ Other Reduction, please specify: _____

*In order to receive a quote for this product, a roster that includes the name, date of birth, gender and volunteer/career status for all members who are to be covered is required.*

## Section 7: Group Critical Illness

Benefits amounts currently offered are $10,000, $20,000 and $30,000. This product is not available in all states.

Desired Effective Date: _____

Number of Members to be Covered: Volunteer: _____ Part-Time: _____ Career: _____

*In order to receive a quote for this product, a roster with names and dates of birth for all members is required.*