PROVIDENT
LAW ENFORCEMENT™

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

Law Enforcement New Business Underwriting Questionnaire

Instructions:

- In order to reserve a proposal for any Law Enforcement 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)

Coverage is subject to exclusions and limitations and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on US state laws.

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: Law Enforcement Information

Type of Organization: ☐ Public Safety Department ☐ Municipal Police Department ☐ Association or Union ☐ Other: _____

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):

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

Population of service area: _____

Square mileage of service area: _____

Service 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 stations: _____

Do you operate an ambulance? ☐ Yes ☐ No

Annual Number of Runs: Annual Calls for Service: _____ Arrests: _____

Criminal Engagement: _____ Other: _____

Number of Vehicles:

Regular: _____ Motorcycle: _____

Speciality: _____ Other: _____

	Number of Lives	Coverage requested?
Number of Career Personnel:	_____	☐
Career Personnel regularly work at least 30 cumulative hours per week for one or more organization(s) identified as a named insured of the policyholder.		
Number of Part-Time Personnel:	_____	☐
Part-Time personnel work less than 30 cumulative hours per week for one or more organization(s) identified as a named insured of the policyholder.		
Number of Volunteer and/or Paid-on-Call Members/Employees:	_____	☐
Volunteers perform services without expectation of any compensation. Paid-on-call members/employees collect nominal remuneration.		
Number of Trustees and/or Directors:	_____	☐
Number of Other Members/Employees:	_____	☐

Please describe: _____

Who is covered by Workers' Compensation (WC)?

Career: ☐ Yes ☐ No ☐ Not Applicable Volunteer: ☐ Yes ☐ No ☐ Not Applicable

What is covered?

☐ Disability ☐ Medical ☐ Both

Carrier Name: _____

Effective Date: _____

What is covered?

☐ Disability ☐ Medical ☐ Both

Carrier Name: _____

Effective Date: _____

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

Does the organization perform annual medical evaluations? ☐ Yes ☐ No

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

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Section 4b: Accident & Health Policy and Benefit Information

Current Insurance Carrier: _____ Current Annual Premium: _____

Current Effective Date: _____

Desired Effective Date: _____

Please include Benefit Declaration Pages

Please include 5-year loss history, if available

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:	Daily Accident Indemnity:
☐ Option 1	$5,000	$2,500	$15
☐ Option 2	$10,000	$5,000	$30

Additional Notes: _____

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Section 5: Accidental Death & Dismemberment

Current Carrier: _____
Current Benefit Amount: _____
Current Effective Date: _____

Current Policy Premium: _____
Desired Benefit Amount: _____
Desired Effective Date: _____

	Number of Lives	Coverage requested?
Number of Career Personnel:	_____	☐
Number of Part-Time Personnel:	_____	☐
Number of Volunteer and/or Paid-on-Call Members:	_____	☐
Number of Trustees and/or Directors:	_____	☐
Number of Other Members/Employees:	_____	☐

Section 6: Group Term Life

Current Carrier: _____
Current Benefit Amount: _____
Current Effective Date: _____

Current Policy Premium: _____
Desired Benefit Amount: _____
Desired Effective Date: _____

Number of Members/Employees to be Covered: _____

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.

Security of information is very important to Provident. Request a secure upload link to submit your roster by emailing rosters@providentins.com OR visit www.providentins.com and click on the Secure File Upload button at the top of the page.

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/Employees to be Covered: _____

***In order to receive a quote for this product, a roster with names and dates of birth for all members is required. Coverage is available* to members younger than 75 years old.**

Security of information is very important to Provident. Request a secure upload link to submit your roster by emailing rosters@providentins.com OR visit www.providentins.com and click on the Secure File Upload button at the top of the page.