



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):

- | | | |
|--|--|---|
| <input type="checkbox"/> Fire | <input type="checkbox"/> Search & Rescue | <input type="checkbox"/> Relief Association |
| <input type="checkbox"/> Rescue | <input type="checkbox"/> Wildland Fire | <input type="checkbox"/> County / State Association |
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Rope Rescue | <input type="checkbox"/> Training School |
| <input type="checkbox"/> First Responder | <input type="checkbox"/> Water Rescue | <input type="checkbox"/> 911 Emergency Dispatch |
| <input type="checkbox"/> Haz Mat | <input type="checkbox"/> Dive Rescue | <input type="checkbox"/> Police |
| <input type="checkbox"/> Hospital EMS | <input type="checkbox"/> Ski Patrol | <input type="checkbox"/> 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 Lives	Coverage requested?
Number of Volunteer and/or Paid-on-Call Members: <i>Volunteers perform services without expectation of any compensation. Paid-on-call members collect nominal remuneration.</i>	_____	<input type="checkbox"/>
Number of Part-Time Personnel: <i>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.</i>	_____	<input type="checkbox"/>
Number of Career Personnel: <i>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.</i>	_____	<input type="checkbox"/>
Number of Trustees, Commissioners and/or Directors:	_____	<input type="checkbox"/>
Number of Other Members:	_____	<input type="checkbox"/>
Please describe: 		

Who is covered by Workers' Compensation (WC)?

Volunteers: Yes No Not Applicable Career: Yes No Not Applicable

What is covered?

Disability Medical Both

What is covered?

Disability Medical Both

Carrier Name: _____

Carrier Name: _____

Effective Date: _____

Effective Date: _____

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



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Section 4b: Accident & Health Policy and Benefit Information

Current Insurance Carrier: _____

Current Premium: _____

Current Effective Date: _____

Current Pay Mode:

Desired Effective Date: _____

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

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:
<input type="checkbox"/> Option 1	\$5,000	\$2,500	\$15
<input type="checkbox"/> Option 2	\$10,000	\$5,000	\$30

Additional Notes: _____



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Section 5: Accidental Death & Dismemberment

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

	Number of Lives	Coverage requested?
Number of Volunteer and/or Paid-on-Call Members:	_____	<input type="checkbox"/>
Number of Part-Time Personnel:	_____	<input type="checkbox"/>
Number of Career Personnel:	_____	<input type="checkbox"/>
Number of Trustees, Commissioners and/or Directors:	_____	<input type="checkbox"/>
Number of Other Members:	_____	<input type="checkbox"/>

Section 6: Group Term Life

Current Carrier: _____ Current Policy Premium: _____
Current Benefit Amount: _____ Desired Benefit Amount: _____
Current Effective Date: _____ Desired Effective Date: _____
Number of Members 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 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.