

## 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 [benefits@providentins.com](mailto:benefits@providentins.com). Thank you for your cooperation.

Date of New Business Submission: \_\_\_\_\_ Date Proposal(s) Needed: \_\_\_\_\_

### Which policies would you like to propose?

- |  |   |
|--|---|
| <input type="checkbox"/> Accident & Health (A&H)                 | <input type="checkbox"/> Group Term Life (GL)         |
| <input type="checkbox"/> Accidental Death & Dismemberment (AD&D) | <input type="checkbox"/> 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: \_\_\_\_\_

**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  Association or Union  
 Municipal Police Department  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):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Police                 | <input type="checkbox"/> Water Rescue               | <input type="checkbox"/> Fire Wildland           |
| <input type="checkbox"/> 911 Emergency Dispatch | <input type="checkbox"/> Rope Rescue                | <input type="checkbox"/> Fire Relief Association |
| <input type="checkbox"/> Search & Rescue        | <input type="checkbox"/> County / State Association | <input type="checkbox"/> Fire                    |
| <input type="checkbox"/> Haz Mat                | <input type="checkbox"/> Training School            | <input type="checkbox"/> Ambulance               |
| <input type="checkbox"/> Rescue                 | <input type="checkbox"/> First Responder            | <input type="checkbox"/> Hospital EMS            |
| <input type="checkbox"/> Dive Rescue            | <input type="checkbox"/> Ski Patrol                 | <input type="checkbox"/> 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.

**Section 4a: Accident & Health Underwriting Information**

Number of stations:

Do you operate an ambulance?  Yes  No

Annual Number of Runs: \_\_\_\_\_ Annual Calls for Service: \_\_\_\_\_  
Criminal Engagement: \_\_\_\_\_

Arrests: \_\_\_\_\_  
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

What is covered?

Disability  Medical  Both

Carrier Name: \_\_\_\_\_

Carrier Name: \_\_\_\_\_

Effective Date: \_\_\_\_\_

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

**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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 Career Personnel:	_____	<input type="checkbox"/>
Number of Part-Time Personnel:	_____	<input type="checkbox"/>
Number of Volunteer and/or Paid-on-Call Members:	_____	<input type="checkbox"/>
Number of Trustees and/or Directors:	_____	<input type="checkbox"/>
Number of Other Members/Employees:	_____	<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/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 [benefits@providentins.com](mailto:benefits@providentins.com) OR visit [providentins.com](http://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 [benefits@providentins.com](mailto:benefits@providentins.com) OR visit [providentins.com](http://providentins.com) and click on the Secure File Upload button at the top of the page.*