Please return this questionnaire to benefits@providentins.com

PO Box 11588 - Pittsburgh, PA 15238
(412) 963-1200 - 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 benefits@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 Lives	Coverage requested?
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 is covered by Workers' Compensation (WC)?

Volunteers: ☐ Yes ☐ No ☐ Not Applicable Career: ☐ 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-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 Effective Date: _____
Desired Effective Date: _____
Please include Benefit Declaration Pages
Please include 5-year loss history, if available

Current Premium: _____
Current Pay Mode:
☐ 1-year annual payment
☐ 3-year annual installment payment
☐ 3-year prepaid payment

Current A&H Benefit Limits

Injury Death Benefit: _____
Illness Death Benefit: _____
Medical Expense Limit: _____
Weekly Disability Limit: _____
Disability Benefit Duration: _____
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: _____
Start date: _____
Number of participants: _____
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 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:	_____	☐
Number of Part-Time Personnel:	_____	☐
Number of Career Personnel:	_____	☐
Number of Trustees, Commissioners and/or Directors:	_____	☐
Number of Other Members:	_____	☐

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 benefits@providentins.com OR visit 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 benefits@providentins.com OR visit providentins.com and click on the Secure File Upload button at the top of the page.