Please return this questionnaire to benefits@providentins.com

PO Box 11588 - Pittsburgh, PA 15238
(412) 963-1200 - providentins.com

Special Risks Questionnaire

Submission Date: _____

Date Proposal(s) Needed: _____

Requested Coverage Effective Date: _____

CUSTOMER 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: _____

Name of Contact: _____ Phone: _____

Email Address: _____ Website: _____

RISK DATA

Type of Group: ☐ Team/League ☐ Club ☐ Association* ☐ Not-for-Profit
☐ Employer ☐ Other ☐ Camps/Clinics

*If Association, please provide copy of by-laws

Description of Covered Persons:

Describe Activities to be Covered:

EXPOSURE

Amount of Exposure - please indicate the # of events, activities, meetings, tournaments, etc.):

Frequency of Exposure: ☐ Daily ☐ Weekly ☐ Monthly ☐ Annually

Total Number of Participants: _____

By Age: 12 & Under _____ 13-15 years _____ Maximum Age: _____
16-18 years _____ 19 & Above _____

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BENEFITS SCHEDULE

Accidental Death & Dismemberment ($): _____

Accidental Paralysis (if available): Yes ☐ No ☐

Accidental Medical Expense Benefit Maximum ($): _____

Medical Expense Coverage: ☐ Excess Only

Deductible ($): ☐ $0 ☐ $100 ☐ $250 ☐ $500 ☐ Other _____

Maximum Benefit Period: ☐ 52 Weeks ☐ 104 Weeks

Do you wish to include travel to and from Covered Activity? Yes ☐ No ☐

Other Requested Benefits: ☐

PRIOR COVERAGE

Is there an accident insurance policy currently in-force? Yes ☐ No ☐

Effective Date: _____

Current/Target Premium ($): _____

Please include Benefit Declaration Pages of in-force coverage.

Please include 5-year loss history, if available.

BROKER INFORMATION

Agency: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ License Number: _____

Email Address: _____ Phone Number: _____