



Please return this questionnaire to reserve@providentbenefits.com.

PO Box 11588 - 272 Alpha Drive - Pittsburgh, PA 15238
(800) 447-0360 - (412) 963-1200 - Fax (412) 963-0415 - providentbenefits.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@providentbenefits.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 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 do you want to cover? Check all that apply as defined above:

- Volunteers Part-Time Career
 Trustees, Commissioners, Directors Others

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: _____

Please list member/employee injury/illness claims suffered during the past three years:

Type and Amount Paid: _____

- 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
Does the organization provide EMS service beyond first aid? 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:

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

Please include Benefit Declaration Pages

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:

Weekly Accident Indemnity:

Option 1

\$5,000

\$2,500

\$105

Option 2

\$10,000

\$5,000

\$210

Additional Notes: _____



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Section 5: Accidental Death & Dismemberment

Current Carrier: _____ Current Policy Number: _____
Current Benefit Amount: _____ Desired Benefit Amount: _____
Current Effective Date: _____ Desired Effective Date: _____
Number of Members to be Covered: Volunteer: _____ Part-Time: _____ Career: _____

Section 6: Group Term Life

Current Carrier: _____ Current Policy Number: _____
Current Benefit Amount: _____ Desired Benefit Amount: _____
Current Effective Date: _____ Desired Effective Date: _____
Number of Members to be Covered: Volunteer: _____ Part-Time: _____ Career: _____
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.

Section 7: Group Critical Illness

Benefits amounts currently offered are \$5,000 and \$10,000. Coverage applies to members ages 18-79. 100% participation of eligible members is required. This product is not available in all states.

Desired Effective Date: _____
Number of Members to be Covered: Volunteer: _____ Part-Time: _____ Career: _____

In order to receive a quote for this product, a roster with names and dates of birth for all members is required.