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EMERGENCY SERVICE ORGANIZATION BLANKET ACCIDENT & HEALTH QUESTIONNAIRE

Name of Organization: _____
Address: _____
City: _____ **Postal Code:** _____
Contact Person: _____ **Position:** _____
Email: _____ **Phone:** _____

Current A&H Benefit Limits:

Injury: Principal Sum: \$ _____ **Illness same as Injury (Y/N)** _____
Weekly Disability Limit: \$ _____ **Auxiliary Benefits: (Y/N)** _____
Hospital Indemnity: \$ _____ **League Athletics: (Y/N)** _____
Medical Expense Limit \$ _____

Current Policy & Underwriting Information: **Premium:** _____ **Expiry Date:** _____

Declaration Pages Enclosed: (Y/N) _____ **Current Insurance Carrier:** _____

Population Area Served on a First Call Basis: _____ **# of Stations:** _____

Annual Number of Runs - **Fire:** _____ **Rescue:** _____ **Ambulance:** _____

Number of Vehicles - **Fire:** _____ **Rescue:** _____ **Ambulance:** _____

Total Number of Members- **Volunteer:** _____ **Career:** _____ **Part-Time:** _____

Haz-Mat (Y/N): _____ **Workers' Compensation: (Y/N):** _____

Losses during the past 3 years (Type & Amount):

Please check appropriate boxes to request information or quotes for the products listed below:

24-Hr AD&D

Group Life

This completed questionnaire is good for either 1 (one) year from the expiration date above or until the next scheduled renewal date, whichever comes first.

PLEASE FAX THIS COMPLETED FORM TO 403.452.0691