EMERGENCY SERVICE ORGANIZATION BLANKET ACCIDENT & HEALTH QUESTIONNAIRE

Name of Organization: _____

Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Contact Person: _____ Position: _____

Email Address: _____ 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:** _____ **Exp 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 Duty (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 ☐ Service Awards

Agent Name: _____ **Phone:** _____

Agency Name: _____ **Email:** _____

Agency Address: _____ **Fax:** _____

Signed by Agent/Broker: _____ **Date:** _____

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.

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INSURING AMERICA'S HEROES SINCE 1928

Please fax to:
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