

EMERGENCY SERVICE ORGANIZATION BLANKET ACCIDENT & SICKNESS QUESTIONNAIRE



Name of Organization: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Contact: _____ Position: _____

Email: _____ Phone: _____

Current Benefit Limits

Accidental Death & Dismemberment: \$ _____

Weekly Disability Limit: \$ _____

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: _____ Number of Stations: _____

Annual Number of Runs - Department: _____ Volunteers: _____ Other: _____

Number of Vehicles - Fire: _____ Rescue: _____ Other: _____

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

Hazardous Materials Duty (Y/N): _____ Worker's Compensation (Y/N): _____

Losses during the past 3 years (Type and Amount): _____

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

On Duty Blanket Accident & Sickness 24-Hour Off Duty Group Life Insurance

Agent Name: _____ Phone: _____

Agency Name: _____ Email: _____

Agency Address: _____ Fax: _____

Signed by Agent: _____ **Date:** _____

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

Benefits for North America's Heroes

Please Fax to:

PROVIDENT AGENCY, INC.
Toll Free Ph: (866) 380-1990 Toll Free Fax: (866) 380-6030
www.providentbenefits.ca

