College Student Accident and Health Underwriting Questionnaire

Section 1 Institutional Information, Census and Plan Types

Name of Institution ______________________________
Street Address ______________________________
City ______________________________ State __________ Zip ______________
Private or Public __________

Person Completing Questionnaire ________________ Title ______________________________

Registered Students		Eligible for Domestic Student Health Plan	If No, Separate Plan
Full-time Undergraduates	__________	Y or N	Y or N
Full-time Graduates	__________	Y or N	Y or N
Part-time Undergraduates	__________	Y or N	Y or N
Part-time Graduates	__________	Y or N	Y or N
Continuing Ed. Students	__________	Y or N	Y or N
How many:			
International Students?	__________	Y or N	Y or N
Study Abroad Students?	__________	Y or N	Y or N
ESL Students?	__________	Y or N	Y or N
Intercollegiate Athletes?	__________	Y or N	Y or N
Male?	__________		
Reside on campus?	__________		
Less than age 23?	__________		
Married?	__________	Spouses Y or N	Y or N
Have children?	__________	Children Y or N	Y or N

Definitions:
What is your definition of a full time student? ______________________________
What is your definition of a part time student? ______________________________
What is your definition of a Continuing Ed student? ______________________________

What separate Student Insurance Policies do you have and on what basis are students enrolled (Check all that Apply)?

Plan Type	Enrollment Method			
__Accident Only	_Compulsory	_Waiver	_Voluntary	_Other______________
__Health Insurance	_Compulsory	_Waiver	_Voluntary	_Other______________
__Optional Higher Limit	_Compulsory	_Waiver	_Voluntary	_Other______________
__International Plan	_Compulsory	_Waiver	_Voluntary	_Other______________
__Study Abroad Plan	_Compulsory	_Waiver	_Voluntary	_Other______________
__ESL (English Language)	_Compulsory	_Waiver	_Voluntary	_Other______________
__Intercollegiate Athletics (Complete Separate Application for Blanket Athletic Policy)	_Compulsory	_Waiver	_Voluntary	_Other______________
__Other____________	_Compulsory	_Waiver	_Voluntary	_Other______________

Section 2 Current Plan Experience and Features

We require prior carrier premium and claims experience for the prior 3 years and the current year. Please complete the experience information requested below for each plan you wish to have quoted (Please provide brochures or policies for each plan for these years).

Policy Year	____	____	____	____
Number of Students Insured	____	____	____	____
Student Rate (Exclusive of Fees)	______	______	______	______
Please Check One:	__Annual	__Semester	__Quarterly	__Monthly
Total Premium	__________	__________	__________	__________
Total Paid Losses	__________	__________	__________	__________
Paid Losses "As of Date"	___/___/___	___/___/___	___/___/___	___/___/___
Agent	_____________	_____________	_____________	_____________
Insurance Company	_____________	_____________	_____________	_____________

Are intercollegiate sports accidents covered under your student health plan? Y / N

If yes, Up to what limit? $____________

Is expanded medical coverage included? Y or N

Is HMO/PPO coverage included? Y or N

Is Heart/Circulatory coverage included? Y or N

(Please complete a Blanket Athletic Underwriting Questionnaire)

Does your current Plan have any of the following optional coverages?

Optional Higher Limit	Y or N		If yes what limit?_________________	
Medical Evacuation	Y or N		If yes what limit?_________________	
Repatriation of Remains	Y or N		If yes what limit?_________________	
Assistance program	Y or N		With Whom?____________________	
Dental Program	Y or N	Check One-	__Insurance	__Discount Card
Vision Program	Y or N	Check One-	__Insurance	__Discount Card

__Other____

Is there any coverage or benefit provided that is not shown in your policy or brochure? Y / N

If yes, describe:____

What Usual and Customary Percentile is used?

_70th _75th _80th _85th _90th _other___

Is the coverage (Check One)? __Excess __Primary __Other________________________

For plans that are enrolled on a Waiver basis, please answer the following questions.

How often are students required to go through the Waiver process? (Check One)

__Each Semester __Every Year __Only Once (Their 1st Year Enrolled) __Other_______________

Are students billed for the insurance with their tuition? Y or N

Are students required to provide comparable (proof of) coverage in order to "waive out" of the Student Plan?

If yes, does the institution do anything to confirm that it is valid and comparable? Y or N

Do you currently grant waiver requests after the published deadline? Y / N

If yes, for what reason?________________________ How often (Check One)? __Never __Rarely __Frequently

What are your payment terms? ____

Do you add any fee to the premium? $__________________

Section 3 On and Off Campus Health Care Provider Information

Which of the following best describes your on-campus student health facility including Mental Health Counseling?

__None
__Dispensary, staffed by registered nurse(s)
__Clinic I, staffed by registered nurse(s) and regularly visited by physician(s) retained to provide on-site services there. Number hours on duty ___________
__Clinic II, like Clinic I, but with salaried physician(s) on-site during daytime periods of operation and on call nights.
__Infirmary, like Clinic I or II, but with __________ overnight facilities.
Periods of operation: __ Hours a day __ Days a week __ Weeks a year
Please attach any brochures describing your on-campus student health facilities.

Which of the following on-campus health services are provided to students for free? (Check All That Apply)

__First Aid	__Controlled drugs/medicines	__Minor Surgery
__Over-the-counter medicines	__Laboratory Tests	__X-rays
__Diagnostic evaluations	__Mental Health Counseling	__Other

Does your current Student Insurance Plan provide benefits for services rendered by a school's health facility? Y or N

If "Yes," list services, usual fees and billing method.

Service	Fee	Billing Method (attach sample of list bills)

What on-campus health service referral requirement is currently part of your student health insurance plan? (Attach or Describe Referral Mechanism)____

Does the school retain any physician(s), clinic(s), or hospital(s) to furnish "free" or "discounted" off-campus care to students? Y / N If yes complete the following:

Provider	Address	Service	Fee	Claim form (Y or N)

Does your current plan utilize a Preferred Provider Organization (PPO)? Y or N

What networks are currently used or preferred? ____________________________

What providers do you require to be included in the network?

Provider	Address

If you have a Pharmacy Plan, which Pharmacy Benefits Manager is it through? _______________________________

What pharmacies must be included in any Pharmacy Plan we propose?

Pharmacy	Address