

ASSOCIATED INSURANCE PLANS INTERNATIONAL, INC. BASIC ATHLETIC ACCIDENT MEDICAL INSURANCE QUOTATION REQUEST FORM

NAME OF INSTITUTION:						
ADDRESS:						
CITY:				_STATE:		ZIP:
PHONE:						
INFORMATION PROVIDED B						
INTORMATION FROVIDED D	, 1,	Name				Title
COVERED PARTICIPANTS		NUMBER (OF PAR	RTICIPANTS		
SPORTS		WOMEN	+	MEN	=	TOTAL
BASEBALL			+		=	
BASKETBALL			+		=	
BOWLING			+		=	
CHEERLEADERS			+		=	
COMPETITIVE CHEER/STUN	T		+		=	
CROSS-COUNTRY			+		=	
DANCE			+		=	
EQUESTRIAN			+		=	
FENCING			+		=	
FIELD HOCKEY			+		=	
FOOTBALL/FALL)			+		=	
FOOTBALL/SPRING)			+		=	
GOLF			+		=	
GYMNASTICS			+		=	
ICE HOCKEY			+		=	
LACROSSE			+		=	
RIFLERY			+		=	
RODEO			+		=	
ROWING/CREW			+		=	
SAILING			+		=	
SKIING			+		=	
SOCCER			+		=	
SOFTBALL			+		=	
STUDENT MANAGERS/TRAIN	NERS		+		=	
SWIMMING			+		=	
DIVING			+		=	
TENNIS			+		=	
TRACK AND FIELD (INDOOR)			+		=	
TRACK AND FIELD (OUTDOO	OR)		+		=	
VOLLEYBALL			+		=	
WATER POLO			+		=	
WRESTLING			+		=	
OTHER (LIST)			+		=	
			+		=	
			+		=	
			+		=	
			+		=	
		-	+		=	
TOTALS			+		=	

NCAA	PREVIOUS INSURANCE INFORMATION YEAR: Current Year	AFFILIATION								
YEAR: Current Year Prior Year Prior Year Prior Year Prior Year BENEFITS:	YEAR: Current Year Prior Year Prior Year Prior Year Prior Year BENEFITS:	□ NCAA □ NAIA □ NJCAA □	OTHER							
BENEFITS:	Maximum Medical	PREVIOUS INSURANCE INFORMATION								
Maximum Medical Deductible Benefit Period Accidental Death Benefit Coverage for Overuse Injuries/Conditions Coverage for Pre-Existing Conditions Yes No Yes Yes No Yes No Yes Yes No Yes No Yes Yes No Yes Yes No Yes	Maximum Medical Deductible Benefit Period Accidental Death Benefit Coverage for Overuse Injuries/Conditions Yes No Yes	YEAR:	Current Year	Prior Year	Prior Year	Prior Year				
Deductible Benefit Period Accidental Death Benefit Coverage for Overuse Injuries/Conditions	Deductible Benefit Period Accidental Death Benefit Coverage for Overuse Injuries/Conditions Yes No Yes Yes Yes	BENEFITS:								
Benefit Period Accidental Death Benefit Coverage for Overuse Injuries/Conditions	Benefit Period Accidental Death Benefit Coverage for Overuse Injuries/Conditions	Maximum Medical								
Accidental Death Benefit Coverage for Overuse Injuries/Conditions Yes No Yes No Yes No Yes No Coverage for Pre-Existing Conditions Yes No Yes No Yes No Yes No Yes No Coverage for HMO/PPO Denials Yes No Yes Yes Yes Yes Yes Yes Y	Accidental Death Benefit	Deductible								
Coverage for Overuse Injuries/Conditions	Coverage for Overuse Injuries/Conditions	Benefit Period								
Coverage for HMO/PPO Denials	Coverage for HMO/PPO Denials	Accidental Death Benefit								
Coverage for Pre-Existing Conditions	Coverage for Pre-Existing Conditions	Coverage for Overuse Injuries/Conditions	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				
Coverage for Heart/Circulatory Conditions	Coverage for Heart/Circulatory Conditions	Coverage for HMO/PPO Denials	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				
Coverage for Guest/Recruit	Coverage for Guest/Recruit	Coverage for Pre-Existing Conditions	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				
PREMIUM: Basic Catastrophe (if purchased) CLAIMS HISTORY:* Number of Claims Paid Dollar Amount of Claims Paid Through (Date) (Month/Year) (Month/Year) (Month/Year) (Month/Year) Please attach carrier loss reports for all years dated no earlier than 3/1 of the current year. OPTIONS TO BE QUOTED: Deductible: \$0 \$250 \$500 \$1,000 Other	PREMIUM: Basic Catastrophe (if purchased) CLAIMS HISTORY:* Number of Claims Paid Dollar Amount of Claims Paid Through (Date) (Month/Year) (Month/Year) (Month/Year) NAME OF INSURER: Please attach carrier loss reports for all years dated no earlier than 3/1 of the current year. OPTIONS TO BE QUOTED: Deductible: \$0 \$250 \$500 \$1,000 Other Coverage for Overuse Injuries/Conditions: Yes No Coverage for Pre-Existing Conditions: Yes Coverage for Guest/Recruit: Yes No Coverage for Heart/Circulatory Conditions: Yes Coverage for Guest/Recruit: Yes No Benefit Period: 1 year 2 year Accidental Death Benefit: \$ Is Catastrophic Coverage desired: Yes No DATE QUOTE NEEDED:	Coverage for Heart/Circulatory Conditions	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				
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Through (Date) (Month/Year)	Through (Date) (Month/Year)	Number of Claims Paid								
Month/Year Month/Year Month/Year Month/Year Month/Year	Month/Year Month/Year Month/Year Month/Year Month/Year	Dollar Amount of Claims Paid								
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OPTIONS TO BE QUOTED: Deductible: \$0 \$250 \$500 \$1,000 Other Coverage for Overuse Injuries/Conditions: \$\ Yes \$\ No \$\ Coverage for Pre-Existing Conditions: \$\ Yes \$\ No \$\ Coverage for HMO/PPO Denials: \$\ Yes \$\ No \$\ Coverage for Heart/Circulatory Conditions: \$\ Yes \$\ No \$\ Benefit Period: \$\ 1 year \$\ 2 year \$\ Accidental Death Benefit: \$\ Xes \$\ DATE QUOTE NEEDED: \$\ \]	OPTIONS TO BE QUOTED: Deductible: \$\Begin{array}{c c c c c c c c c c c c c c c c c c c	NAME OF INSURER:								
Coverage for Overuse Injuries/Conditions:	Coverage for Overuse Injuries/Conditions: Yes No Coverage for Pre-Existing Conditions: Yes Coverage for HMO/PPO Denials: Yes No Coverage for Heart/Circulatory Conditions: Yes Coverage for Guest/Recruit: Yes No Benefit Period: 1 year 2 year Accidental Death Benefit: Is Catastrophic Coverage desired: Yes No DATE QUOTE NEEDED:		d no earlier than	3/1 of the current	year.					
Coverage for HMO/PPO Denials:	Coverage for HMO/PPO Denials:	Deductible: \square \$0 \square \$250 \square \$500	□ \$1,000 □	Other						
Coverage for Guest/Recruit:	Coverage for Guest/Recruit:	Coverage for Overuse Injuries/Conditions: \square Yes \square No Coverage for Pre-Existing Conditions: \square Yes \square I								
Benefit Period:	Benefit Period:	Coverage for HMO/PPO Denials: \Box Ye	es 🗆 No Co	verage for Heart	Circulatory Con	ditions: \square Yes				
Is Catastrophic Coverage desired: Yes No DATE QUOTE NEEDED:	Is Catastrophic Coverage desired: Yes No DATE QUOTE NEEDED:	Coverage for Guest/Recruit: \Box Ye	es 🗆 No							
DATE QUOTE NEEDED:	DATE QUOTE NEEDED:	Benefit Period: 🗆 1	year 🗆 2 year	A	accidental Death	Benefit: \$				
		Is Catastrophic Coverage desired: \Box Ye	es 🗆 No							
ADDITIONAL INFORMATION: (Please use separate sheet if necessary)	ADDITIONAL INFORMATION: (Please use separate sheet if necessary)	DATE QUOTE NEEDED:								
ADDITIONAL ORGANITORS (I rease use separate sheet is necessary)	ADDITIONALI II ORMANION (Trease use separate succe ii necessary)			arv)						
		ADDITIONAL IN ORMATION. (Hease use separa	are sheet if hecess	y <i>)</i>						

RETURN THIS COMPLETED FORM TO: Associated Insurance Plans International, Inc.



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Burlington, WI 53105
800-452-5772
Fax: 906-914-9253
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