STUDENT ACCIDENT

Student Accident.net

College Student Accident and Health Questionnaire

Section 1 Institutional Information, Census and Plan Types

Name of Institution ______________________________

Street Address ______________________________

City ______________________________ State __________ Zip__________

Website _______________ 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	Spouses Y or N
Have children?	________	Children Y or N	Children 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? ______________________________

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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	_Compulsory	_Waiver	_Voluntary	_Other____________

(Complete Separate Application for Blanket Athletic Policy)

__Other ______________	_Compulsory	_Waiver	_Voluntary	_Other____________

Section 2 Current Plan Experience and Features

We require 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 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 or 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 coverage?

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 One- __Insurance __Discount Card

Vision Program Y or N One- __Insurance __Discount Card

__Other____

Is there any coverage or benefit provided that is not shown in your policy or brochure? Y or 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 administered 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 student billed for the insurance with their tuition? Y or N

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

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 or 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 or 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