MEBA
ADMINISTRATION
CONSULTING
INSURANCE BROKERS
INTERNATIONAL

Please return this questionnaire to John@meba.ca
MEBA
5-2600 Skymark Ave., Suite 100
Mississauga, ON L4W 5B2
Phone: (905) 629-1868 Toll Free: (877) 275-6322 Fax: (905) 275-6322

Emergency Service Organization Underwriting Questionnaire

Instructions:

- In order to reserve a proposal for any Emergency Service Organization product, Sections 1 and 2 must be completed in full. This reservation will be good for 90 days from the date of submission or until the date proposals are needed, whichever is longer.
- Section 3 must be completed in full in order to receive a proposal for any policy type.
- In order to obtain an Accident & Health proposal, Sections 4a and 4b must also be completed in full
- In order to obtain a proposal for other group products, please complete Section 5 and/or 6 and/or 7. Also, include a roster for Group Critical Illness proposals.
- Please do not leave blanks. Use N/A or zero if necessary.

Once you have compiled the necessary information and completed this questionnaire, please email all documents to John@meba.ca. Thank you for your cooperation.

Date Submitted: ______________ Proposal Needed By: ______________

Which coverage would you like to propose? ☐ ON DUTY ☐ OFF DUTY ☐ Critical Illness

Section 1: General Policyholder Information

Organization Name: ______________ (As it should appear in policy) Website: ______________

Street Address: ______________ Box / Other: ______________

City: ______________ Prov.: ______ P/C: ______________

Contact Person: ______________ Phone: ______________ Phone: ______________

Position: ______________ Email: ______________

Section 2: Broker Information

Agency Name: ______________

Address: ______________

City: ______________ Prov.: ______ P/C: ______________

Phone: ______________ Fax: ______________

Website: ______________

Broker Name: ______________ Title: ______________

Cell Phone: ______________ License #'s: ______________

Broker Email: ______________

Service Rep: ______________ Title: ______________

Service Rep. Phone: ______________ Email: ______________

Section 3: Emergency Service Organization Information

Type of Organization:	Fire District Independent Department		Municipally Based Other (Describe):
Is the organization incorporated:	Yes / No		
Organization Status:	Government	For-Profit	Not-for-Profit

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Type of Services Provided: (check all that apply)	Fire Medical Assist Rescue Search & Rescue Ski Patrol Wildland Fire	Ambulance First Responder Rope Rescue Regional Association Training School Water Rescue	911 Emergency Dive Rescue Dispatch Haz Mat Motor Vehicle Incident Police Other: ___________
Population served on 1st Call basis:			
Square kilometers of 1st call area:			
First Call area is primarily:	Rural	Suburban	Urban

Named Insureds:

____

____

____

If there are multiple entities covered by the policyholder, please include a list with the name and address of each entity.

Section 4a: Accident & Health Underwriting Information		
Number of locations with emergency operations:		
Do you operate an ambulance?	Yes No	
Annual Number of Runs:	Fire and other non-medical runs: Emergency medical or first responder medical: Non-emergency transports:	
Number of Vehicles:	Fire: Rescue: Ambulance: Other:	
Number of Volunteer and/or Paid-on-Call Members: *Volunteers perform services without expectation of any compensation. Paid-on-Call members collect nominal remuneration.*		
Number of Part-Time Personnel: *Part-time personnel work less than 30 cumulative hours per week as emergency service providers for one or more organization(s) identified as a named insured of the policyholder.*		
Number of Career Personnel: *Career personnel regularly work at least 30 cumulative hours per week as emergency service providers for one or more organization(s) identified as a named insured of the policy holder.*		
Number of Trustees, Commissioners and/or Directors:		
Number of Other Members: (Please describe)		
Who do you want to cover? (Check all that apply as defined above)	Volunteers Board Careers	Others (specify) Part-Time

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Who is covered by Workers' Compensation?	
Volunteers: Yes No N/A	Career: Yes No N/A
Please list member/employee injury/illness claims suffered during the past three years. Type and amount paid: ____________________ ____________________ ____________________	
Does the organization perform pre-membership medical screenings?	Yes No
Does the organization perform annual medical evaluations?	Yes No
Does the organization have a Safety Officer?	Yes No
Does the organization provide EMS service beyond first aid?	Yes No

Section 4b: Accident & Health Policy and Benefit Information		
Current Insurance Carrier: Current Premium: Current Effective Date:	Current Pay Mode: 1-year annual payment 2-year annual installment payment 3-year prepaid payment	
Please include Benefit Declaration Pages		
Current A&H Benefit Limits:		
Death Benefit: ($5,000 - $500,000) Plan 1: __________ Plan 2: __________ Plan 3: __________	Weekly Disability: ($50 - $1,000) Plan 1: __________ Plan 2: __________ Plan 3: __________	Medical Expense: ($2,500 - $250,000) Plan 1: __________ Plan 2: __________ Plan 3: __________