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Student Accident Insurance Request for Quote Form

NOTE: Some browsers may not support full PDF functionality. In those instances, please download this form, complete and return to: underwriting@getpomi.com

Requested Effective Date of Coverage _____ Quote Due Date _____

School Information

Name _____

Contact _____ Email _____

Address _____ City _____

State _____ Zip Code _____ Website _____

Do you currently have a Student Accident Program? Yes No

If yes, please provide a copy of the current policy.

Do you have interscholastic sports? Yes No

Estimated Number of Students (per grade)

Kindergarten & below _____ Grades 1-6 _____

Grades 7-8 excluding interscholastic sports _____ Grades 7-8 including interscholastic sports _____

Grades 9-12 excluding interscholastic sports _____ Grades 9-12 football _____

Grades 9-12 including interscholastic sports except football _____

Overnight Field Trips (per school/school year) _____

Estimated Number of Participants: Volunteers _____

Type of Coverage

School Time 24-Hour Mandatory Travel to and from sponsored activities

Previous Experience Current Year 20 _____ 20 _____ 20 _____ 20 _____ 20 _____

Premium _____

Paid Claims _____

As of Date _____

Insurance Carrier _____

If there is prior experience, please provide loss runs

Desired Benefits

Accidental Death \$ _____

Accidental Dismemberment \$ _____

Accidental Paralysis \$ _____

Desired Benefits Continued

Accidental Medical Expense					\$ _____
<input type="checkbox"/> Excess	<input type="checkbox"/> Primary				
Maximum Benefit Period	<input type="checkbox"/> 52 Weeks	<input type="checkbox"/> 104 Weeks		Yes	No
Catastrophic Coverage					<input type="checkbox"/> <input type="checkbox"/>
Limit Options	<input type="checkbox"/> \$1M	<input type="checkbox"/> \$3M	<input type="checkbox"/> \$6M	<input type="checkbox"/> Other _____	
Other Benefits Requested _____					
Aggregate Limit per Occurrence <i>(Standard is 10 times the Accidental Death Benefit)</i>					\$ _____

Producer Information

Name of Agency _____						
Name of Contact _____						
Street Address _____						
City _____	State _____	Zip Code _____				
Phone Number _____	Email _____					
Requested Commission <i>(15% is standard)</i> _____						
Are you a licensed A&H producer in the applicable risk state(s)?					Yes	No
					<input type="checkbox"/>	<input type="checkbox"/>
Are you an appointed producer with Great American Insurance Company?					<input type="checkbox"/>	<input type="checkbox"/>

I hereby acknowledge that all answers and statements contained on this form and any attachments are complete and accurate. I also understand that no coverage will become effective until an application has been approved by the Company.

Signature _____ **Date** _____

Submit