ASSOCIATED INSURANCE PLANS
INTERNATIONAL, INC.

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Libertyville, Illinois 60048
800.452.5772
847.537.6958 fax
www.AIPstudentinsurance.com

Request for Proposal

NAME _____ TITLE _____

COLLEGE OR UNIVERSITY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ EMAIL _____

I am interested in receiving information on the following insurance programs:

- ○ Student Health Insurance *(please include a copy of current plan)*
- ○ Number of students: _____ FULL TIME _____ PART TIME _____ GRADUATES
- ○ Intercollegiate Athletic Insurance *(complete reverse side)*
- ○ Dental, Vision or Pharmacy Program ○ GROUP PLAN ○ INDIVIDUAL PLAN
- ○ International Student insurance. We have approximately _____ International Students.
  Now covered: ○ MANDATORY ○ VOLUNTARY ○ COVERED UNDER STUDENT PLAN ○ COVERED UNDER SEPARATE PLAN
- ○ Other _____

Student Health Insurance

Q Are international students insured through your student plan or a separate plan? _____
○ MANDATORY ○ WAIVER ○ VOLUNTARY

Q Are intercollegiate athletic injuries covered by your current student insurance plan? ○ YES ○ NO
If yes, please complete census information on the reverse side of this form.

Loss History

Complete the following for the current year and the past two years. *If possible, include any printed literature describing your present student health insurance plan. Please include any computerized claims payment information which may be provided by your current underwriting company.*

List Policy Year	_____ TO _____	_____ TO _____	CURRENT YEAR _____ TO _____
Number of Insured Students	_____ _____	_____ _____	_____ _____
Cost per Insured Students	_____ _____	_____ _____	_____ _____
Total Premiums	_____ _____	_____ _____	_____ _____
Claims Paid	_____ _____	_____ _____	_____ _____
Underwriting Company	_____ _____	_____ _____	_____ _____

Q Do you prefer local service by an agency of your choice? If so, please provide their name, address and telephone number:
_____

Q Type of enrollment: ○ MANDATORY ○ VOLUNTARY ○ WAIVER ○ OTHER _____

DATE _____ DEADLINE FOR RECEIPT _____

Intercollegiate Athletic Insurance Census

Please indicate numbers of participants below.

Sport	Male	Female	Sport	Male	Female	Sport	Male	Female
Band	_____	_____	Football-Spring	_____	_____	Soccer	_____	_____
Baseball	_____	_____	Football-Tryouts	_____	_____	Softball	_____	_____
Basketball	_____	_____	Golf	_____	_____	Swimming	_____	_____
Cheerleaders	_____	_____	Gymnastics	_____	_____	Tennis	_____	_____
Cross Country	_____	_____	Ice Hockey	_____	_____	Track	_____	_____
Equestian	_____	_____	Lacrosse	_____	_____	Volleyball	_____	_____
Fencing	_____	_____	Rodeo	_____	_____	Wrestling	_____	_____
Field Hockey	_____	_____	Rugby	_____	_____	Coaches	_____	_____
Football	_____	_____	Skiing	_____	_____	Trainers	_____	_____
Sport not listed	_____	_____ _____ (Name)	Sport not listed	_____	_____ _____ (Name)	Managers	_____	_____

Previous Coverage

Underwriting Company _____

Medical Expense Maximum _____

AD&D Benefit _____

Deductible (football) _____

Deductible (_____) _____

Deductible (all other) _____

Vanishing Deductible ○ YES ○ NO

Benefit Period ○ 52 WEEKS ○ 104 WEEKS

Coordination with HMO/PPO ○ YES ○ NO

Expanded Medical ○ YES ○ NO

Managed Care Network Utilized ○ YES ○ NO

Physiotherapy Limit ○ YES ○ NO

Heart & Circulatory ○ YES ○ NO

Loss History – List Policy Year _____ TO _____ _____ TO _____ CURRENT YEAR _____ TO _____

Premium	_____	_____	_____	_____	_____	_____
Medical Claims Paid	_____	_____	_____	_____	_____	_____
AD&D Claims Paid	_____	_____	_____	_____	_____	_____
Paid (as of) date	_____	_____	_____	_____	_____	_____
Number of claims paid by Carrier	_____	_____	_____	_____	_____	_____

Please provide reports which show excess claims

Shock Losses Paid

Claims in excess of $10,000 (number and dollar amounts)_____

_____

_____

Please indicate any changes in coverage or deductible in which you may have interest.

_____