ASSOCIATED INSURANCE PLANS
INTERNATIONAL, INC.

DATE
DEADLINE

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*)
- ○ Intercollegiate Athletic Insurance (*complete reverse side*)
- ○ Short Term or "In Between" Protection
- ○ Dental, Vision & Pharmacy Program
- ○ International Student Insurance. We have approximately _____ International Students.
  Now covered: ○ MANDATORY ○ VOLUNTARY
- ○ Other _____

Student Health Insurance

In order to present you with the lowest possible cost, please answer the following questions:

Number of Students _____ Percentage of Commuters _____

Do you have an infirmary? ○ YES ○ NO If so, Number of Beds _____ Dispensary ○ YES ○ NO

Are there nurses? ○ YES ○ NO ○ WITH OFFICE HOURS ○ FULL-TIME

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.*

	TO	TO	TO	CURRENT YEAR
Number of Insured Students				
Cost per Insured Students				
Total Premiums				
Claims Paid				

What Agency handles your present plan? _____

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

_____

Do you wish our proposal to be: ○ MANDATORY ○ VOLUNTARY ○ WAIVER ○ OTHER _____

28085 Ashley Circle, Suite 201, Libertyville, Illinois 60048
800.452.5772 847.537.6958 fax www.AIPInternational.com

Intercollegiate Athletic Insurance

In order to present you with the lowest possible cost, please answer the following questions:

Please indicate numbers of participants below.

Sport	Male	Female	Sport	Male	Female	Sport	Male	Female
Band			Football–Tryouts			Softball		
Baseball			Golf			Swimming		
Basketball			Gymnastics			Tennis		
Cheerleaders			Ice Hockey			Track		
Cross Country			Lacrosse			Volleyball		
Fencing			Rodeo			Wrestling		
Field Hockey			Rugby			Coaches		
Football			Skiing			Trainers		
Football–Spring			Soccer			Managers		

Previous Coverage	____TO____	____TO____	____TO____	CURRENT YEAR
Carrier				
Medical Expense Maximum				
AD&D Benefit				
Deductible (football)				
Deductible (_____)				
Deductible (all other)				
Vanishing Deductible				
Benefit Period				
Coordination with HMO/PPO	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Expanded Medical				
Coinsurance Percentage	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Managed Care Network Utilized	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Excess or Primary				
Physiotherapy Limit	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Orthopedic Appliance Limit	○ EXCESS ○ PRIMARY	○ EXCESS ○ PRIMARY	○ EXCESS ○ PRIMARY	○ EXCESS ○ PRIMARY
Previous Experience				
Premium				
Medical Claims Paid				
AD&D Claims Paid				
Paid as of Date				
Number of Claims paid by Carrier				
Shock Losses Paid				
Number of claims in excess of $10,000				
Number of claims in excess of $25,000				
Number of claims in excess of $50,000				

(*If available, please provide reports which show excess claims.*)

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