STUDENT ACCIDENT INSURANCE
QUOTE REQUEST FORM

CIGNA Group Insurance
Life • Accident • Disability

School Name: ______________________ School Contact: ______________________

Address: ______________________ City: __________ State: _____ Zip: _____

Email: ______________ Phone: (_____)__________ Fax: (_____)__________

Agent Name: ______________________ Agency: ______________________

Address: ______________________ City: __________ State: _____ Zip: _____

Email: ______________ Phone: (_____)__________ Fax: (_____)__________

Requested Effective Date of Coverage: ______________

1. Do you currently have a Student Accident Program?

❑ Yes ❑ No *(If Yes, please provide a copy of your current policy's schedule page.)*

2. Do you have Interscholastic Football?

❑ Yes ❑ No

3. Estimated Number of Students:

Grades	Student Enrollment
Pre-K - 8	________
9 - 12	________

4. Is this a Boarding School:

❑ Yes ❑ No

5. Previous Experience:

	Current Year	20___	20___	20___	20___
Premium					
Paid Claims					
As of Date					
Insurance Carrier					

Request for Quote:
Please provide a Student Accident Insurance quote based on the information provided on this form and any attachments. To the best of my knowledge, all information provided is complete and accurate.

Signed: ______________________ Title: ______________ Date: ______________

Please return form to: Employers Mutual, Inc., 700 Central Parkway, Stuart, FL 34994
Phone: **1-800-431-2221** • Fax: **1-772-287-1387**