

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:

TL Groseclose Associates, Inc., 190 Tamarack Circle, Skillman, NJ 08558
Phone: **1-609-279-1500** • Fax: **1-609-279-1535**