Prospective Insured Information

Legal Name of Prospective Policyholder: ________________ Tax ID Number: ________

Mailing/Street Address: ________________ City: ________ State: ______ Zip: ______

Primary Contact: ________________ Title: ________________

Email: ________________ Phone: ________________

Existing Coverage Information

Do you currently have insurance for off-site medical expenses? ◯ Yes ◯ No

If yes, who is your current carrier? ________________ Current Total Annual Premium: ________

If possible, please provide a copy of your current insurance policy when submitting this questionnaire.

Desired Coverage:

What is your desired effective date? ________________

Prior-to-Booking/In-Pursuit Coverage: ◯ Include ◯ Exclude ◯ Pre-Booking only (usually a city)

Security & Guarding Coverage (may impact minimum eligibility requirements): ◯ Include

Detention Facility Information

Check here if not applicable (i.e., a city or county without a jail): ◯

Name of Facility: ________________ Max Jail Capacity: ________

Facility Address: ________________ City: ________ State: ______ Zip: ______

For the average and current inmate population, count only those for which you are financially responsible, including any inmates housed at other facilities; exclude all inmates for whom you are not financially responsible.

Average monthly inmate population for the past 12-months: ________ Current inmate population: ________

List any other detention facilities that you use to house inmates and the approximate number at each; these numbers should be included in the figures above (if additional lines are required please include them in the Additional Comments on Page 2):

Facility Name	City, State	Count

Contracted / Negotiated Rates with Medical Providers

Do you contract with an on-site healthcare provider? ◯ Yes ◯ No If yes, who? ________________

Please check the following option that best describes how off-site medical bills are handled (outside of legislation):

◯ Negotiated and paid by staff of the County, Sheriff, or City staff

◯ Reviewed and negotiated by on-site Healthcare Provider

◯ Reviewed and negotiated by off-site Third Party Claims Administrator; if yes, what is their fee? ________

◯ Other: ________________

Does your jail have medical personnel: ◯ On-site 24/7 ◯ On-call ◯ Neither

Additional comments about on-site medical care: ________________

Does the state in which the facility is located have legislation that limits medical expenses for indigent care? ◯ Yes ◯ No

Comments: ________________

List the the top three hospitals you use and the contracted rate at which medical expenses are paid:

Hospital	Contracted / Negotiated Rate / Comments

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Claim History

List all inmate medical claims incurred outside the walls of your jail that exceeded a total of $10,000 per inmate, during the previous rolling 24-months. You may use the lines below or submit this in an excel spreadsheet (preferred).

Inmate Name	Date(s) of Service	Primary Diagnosis/Nature of Injury or Illness	Hospitalized Prior-to or Post Booking?	Amount Billed from Medical Provider (Before Discounts)	Amount Paid to Medical Provider (After Discounts)	Pending Payment to Medical Provider

Are any of these inmates currently still in custody? ◯ Yes ◯ No

If yes, please indicate their name(s) and current prognosis:

Name ______________________ **Prognosis** ______________________

______________________ ______________________

______________________ ______________________

Are there any inmates currently off-site (inpatient) at this time? ◯ Yes ◯ No

Name ______________________ **Prognosis** ______________________

______________________ ______________________

______________________ ______________________

Additional Comments

Please use the lines below to provide additional information you would like us to know.

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Any person who knowingly and with intent to injure, defraud or deceive any insurer; files a statement of claim or a questionnaire containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Printed Name: ______________________ Title: ______________ Date: ______________

Prospective Insured Signature: ______________________________

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