First Agency, Inc.
5071 West H Ave.
Kalamazoo, MI 49009
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E-Mail: 1stagency@1stagency.com

STUDENT HEALTH REQUEST FOR INFORMATION

Name of College/University: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

RESPONSIBLE SCHOOL OFFICIAL:

Name: _____ Phone: _____

Title: _____ E-Mail: _____

TYPE OF PLAN: (Check all applicable. Please send a brochure of your present Student Health Plan.)

- ☐ Mandatory Accident
- ☐ Voluntary Accident
- ☐ Waiver Accident
- ☐ Other (Describe) _____
- ☐ Mandatory Sickness
- ☐ Voluntary Sickness
- ☐ Waiver Sickness
- ☐ Other (Describe) _____

Current Year Number of Students in College	Men	_____	Women	_____
Current Year Number of Students on Insurance Plan	Men	_____	Women	_____
Current Year Number of Resident Students Total	Men	_____	Women	_____

LOSS EXPERIENCE INFORMATION: (If benefits were changed in the past 3 years, please send a copy of the brochure for the appropriate year(s).

Year	Total Premiums	Paid Claims	Number of Insured Claimants
_____	$ _____	$ _____	_____
_____	$ _____	$ _____	_____
_____	$ _____	$ _____	_____
_____	$ _____	$ _____	_____

PREMIUM RATES: (Indicate rates charged for the current and past three years.)

Year	_____	_____	_____	_____
Student	$ _____	$ _____	$ _____	$ _____
Student/Spouse	$ _____	$ _____	$ _____	$ _____
Student/Spouse/Child(ren)	$ _____	$ _____	$ _____	$ _____

ALTERNATE QUOTES:

Based on your current plan, would you like additional quotes to increase, decrease or add specific benefits, i.e. Room & Board, Mental & Nervous? If so, please specify.

_____

_____

_____

Please enclose additional information which describes the current or previous insurance coverage, Student Health Services or that otherwise expands upon the insurance requested herein.

HEALTH SERVICE INFORMATION:

Do you have an Infirmary? ☐ Yes ☐ No Dispensary? ☐ Yes ☐ No Number of Beds? _____

What services are provided FREE of charge to students? _____

Date quote needed: _____