

Accident Medical Application

Child Care Centers, Nursery Schools, Head Start Programs and Montessori Schools.

Proposed Policyholder Name _____

Street Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____

Business Type Individual Corporation Partnership Other _____

Profit Nonprofit

Child Care Center no camp Child Care Center with camp Montessori Nursery School Head Start

Other _____

Proposed Effective Date _____

Proposed Expiration Date _____

Plan Chosen Plan 1 (C1)

Plan 4 (C4)

Term of Coverage Annual Term

9-Month Term

Number of Insured Persons

Students under Age 7 _____ x _____ rate = \$ _____

Students Age 7 and over _____ x _____ rate = \$ _____

Total Number of Insureds _____ \$ _____

Total Premium
(\$350 Minimum Earned Premium)

Premium & Loss History Past 3 Years:

Policy Year _____ _____ _____

Total Premium \$ _____ \$ _____ \$ _____

Total Incurred Claims \$ _____ \$ _____ \$ _____

Number of Claims _____ _____ _____

Name(s) of Insurance Carrier(s) _____ _____ _____

^W Check here if no prior coverage.

Coverage shall not be bound until the Company approves the applicant's completed application and full premium payment is received. The Company's receipt of premium does not bind coverage until the completed application is also approved. In the event the Company does not approve your application, your premium payment will be refunded.

FAIR CREDIT REPORT ACT NOTICE—An investigative consumer report may be requested by the insurer to which this application is assigned as to the consumer's character, general reputation, personal characteristics, and mode of living. Subsequent consumer reports may be requested in connection with an update or renewal, or extension of the insurance which this application is made. The applicant will be informed of the name and address of the consumer reporting agency that furnished the report.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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Applicant's Signature _____

Date _____

Phone Number _____

Producer's Name _____

Street Address _____

City _____

State _____

Zip _____

Phone Number () _____

Fax Number () _____

Accident Medical Protection For

Child Care Centers, Nursery Schools, Head Start Programs and
Montessori Schools.

Plan 1

Accidental Death & Dismemberment \$10,000
Accident Medical Expense \$12,500

<u>Plan</u>	<u>Annual Term</u>		<u>9-Month Term</u>	
C1	Under Age 7:	\$5.75	\$0 Deductible	\$4.20
	Age 7 & Over:	\$9.20		\$6.45

Plan 4

Accidental Death & Dismemberment \$10,000
Accident Medical Expense \$20,000

<u>Plan</u>	<u>Annual Term</u>		<u>9-Month Term</u>	
C4	Under Age 7:	\$5.90	\$0 Deductible	\$4.30
	Age 7 & Over:	\$9.45		\$6.70

Minimum Earned Premium for Either Option: \$350.
(Rates Subject to Change)