

Business Travel Accident Program

Request for Proposal



Quote Due Date: _____

Req. Effective Date: _____

Customer Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____

Email: _____

Nature of Business: _____ Standard Industrial Classification (SIC): (if known) _____

Does the customer currently have other lines of coverage with The Hartford? Yes No

Prior Coverage

• Is there a business travel accident policy currently in-force? Yes No In Force Premium Amount: _____

* Please attach all available details of current program, including coverage, benefits, limits provided, copy of current contract and a minimum of three (3) years' premium and loss experience.

Travel Assessment

• Please complete the chart below including Class Descriptions, Benefit Amounts, Type of Coverage, and applicable travel information. In addition, please include the number of truck drivers, chauffeurs, and/or deliverymen per class if coverage is desired. Attach a separate sheet of paper if additional room is needed. Please write "N/A" if an item does not apply.

	Class 1	Class 2	Class 3	Class 4
Class Description: (i.e. Managers, Sales, All Employees)				
Benefit Amount Desired:**				
Type of Coverage: (Business Travel Only or Business and Pleasure)				
Total Number of Insureds:				
Number of Insureds who travel on Business:				
Over 50 days per year*				
26-50 days per year*				
10-25 days per year*				
1-9 days per year*				
0 days per year*				
# of truck drivers, chauffeurs, and/or deliverymen				
Average Salary of Travelers**				

*Any time away from the office (business lunches, client visits, etc) is considered a day of travel.

**If salary is used to determine the benefit for a Class, please attach a salary census for all the insureds in that Class.

• How many vehicles does your company own? _____

• Are there more than 50 employees employed in the state of California? Yes No

Aggregate Limit

• What is the desired Aggregate Limit per Accident? _____

Affiliated Companies/Subsidiaries

• List Affiliated Companies/Subsidiaries to be included under this program and their nature of business. Remember to include the Affiliated Companies' travel exposure in the Assessment above.

Foreign Employees

- Do you have any foreign employees to be covered under this plan? Yes No

If yes, please list the country and the number of employees in the chart below. For Canada, please specify the Province.

Work Country	Country of Citizenship	Number of Employees

Company Aircraft

- Does your company own, operate, or lease any aircraft? Yes No If yes, please complete the chart below.

Year	Make & Model	FAA or Serial #	Crew Seats	Passenger Seats	Avg. Occupancy	Avg. Usage

- Do you wish to cover employee pilots? If yes, please list their names and their respective type of pilot license.

70 and Over Employees

- Are there any employees age 70 or greater that are to receive full benefits? Yes No If yes, please complete the chart below. If no, our standard benefit reduction schedule will apply. This schedule reduces benefits applicable to employees' age 70 or greater.

Date of Birth	Class Number

War Risk Coverage

- Is War Risk Coverage* desired? Yes No If yes, please complete the chart below.

Visited Country	Length of Stay	Average Number of Trips

*War or act of war is a standard exclusion on Travel Accident policies. In order to have coverage for losses resulting from war or acts of war, war risk coverage must be purchased.

Agency Information

Completed by: _____ Date: _____
 Agency Name: _____ Agent Name: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____ Agency Tax ID #: _____
 Email: _____
 Signature of Licensed Agent: _____

The Hartford's standard level of commissions is 15%. If different, please indicate. _____