

# 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
<b>Class Description:</b> (i.e. Managers, Sales, All Employees)				
<b>Benefit Amount Desired:**</b>				
<b>Type of Coverage:</b> (Business Travel Only or Business and Pleasure)				
<b>Total Number of Insureds:</b>				
<b>Number of Insureds who travel on Business:</b>				
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.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Expertise without equal.  
 Benefits without burden.<sup>SM</sup>

**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. \_\_\_\_\_**

### **Group Benefits Disclosure Notice**

The Hartford compensates both internal and external producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions regarding your insurance producer's compensation directly to your insurance producer. For specific questions on The Hartford's internal producers, please contact our Customer Service 800 number (800-523-2233).