

# GROUP TRAVEL ACCIDENT

## Request for Insurance

Complete all information required and return to your Hartford agent

Underwriting Companies:  
Hartford Fire Insurance Company Hartford Life Insurance Company

### CHECK TYPE OF COVERAGE DESIRED

- Business only
- Business and Pleasure
- A.  24 hr. All Risk (Business and Pleasure)
- Other Coverage (Please Specify) \_\_\_\_\_
- B. All Risk while on trip (Excluding vacations, commutation and leaves of absence.) Business only.
  - Outside city limit of permanent assignment
  - Inside and Outside city limit
- C.  All Conveyance
- D.  Common Carrier
- E.  Civilian Aircraft
- F.  Scheduled Airline

1. Name of Firm: \_\_\_\_\_  
Home Office Address: \_\_\_\_\_  
City and State: \_\_\_\_\_
2. Nature of Business: \_\_\_\_\_
3. Location of Plants: \_\_\_\_\_  
Sales Offices: \_\_\_\_\_  
Are all Controlled Companies to be included in plan?  
Yes  No

4. Effective Date: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_
5. Does your firm now carry Travel Insurance? Yes  No   
Present Company? \_\_\_\_\_  
Please provide loss experience:  
Policy Year 19 \_\_\_\_ 19 \_\_\_\_ 19 \_\_\_\_  
Total Premium \$ \_\_\_\_ \$ \_\_\_\_ \$ \_\_\_\_  
Total Incurred Claims \$ \_\_\_\_ \$ \_\_\_\_ \$ \_\_\_\_  
Total Number of Claims \$ \_\_\_\_ \$ \_\_\_\_ \$ \_\_\_\_  
Name of Prior Carrier: \_\_\_\_\_
6. Total number of employees:  
Salaried \_\_\_\_\_ Hourly \_\_\_\_\_ Commissioned \_\_\_\_\_
7. Are Truck Drivers, Helpers, Chauffeurs, Deliverymen to be covered? Yes  No  If so, how many? \_\_\_\_\_  
Type of Trucks? \_\_\_\_\_
8. Is there a rule limiting the number of employees traveling together? Yes  No   
What is the maximum number of employees ever traveling together? \_\_\_\_\_
9. How many company-owned, leased or privately-owned automobiles are used on company business? \_\_\_\_\_

10. Describe unusual or occupational hazards of those to be covered: \_\_\_\_\_
11. A. Is the plan to include coverage on company-owned or leased aircraft? Yes  No   
If Yes, should coverage apply to:  
Employees? Yes  No   
Crew? Yes  No  (See Note Below)
- B. If Yes, what is the maximum load limit at any one time? \_\_\_\_\_
- C. How often is company-owned or leased aircraft used during the year? \_\_\_\_\_
12. Does your firm ever (or intend to) charter or rent aircraft? Yes  No
13. Are your employees authorized to charter or rent aircraft? Yes  No   
If Yes, please explain \_\_\_\_\_
14. Are there any employees to be covered age 70 or over? Yes  No   
If Yes, list their ages and applicable class number. \_\_\_\_\_

Class Number	1	2	3	4	5
<b>CLASS OF EMPLOYEES TO BE COVERED</b> Describe by Title, Nature of Position, Name, Salary Breakdown or Blanket.	_____	_____	_____	_____	_____
<b>BENEFIT AMOUNTS</b>					
Is Permanent Total Disability Desired?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Accidental Death and Dismemberment	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Accident Medical Expense	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Accident Total Disability	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>Total Number of People in Class</b>					
Number in Class who travel on business	_____	_____	_____	_____	_____
Number who Travel on business over 75 days a Year	_____	_____	_____	_____	_____
Total Number of days away on business by those traveling less than 75 days a Year	_____	_____	_____	_____	_____

NOTE: If coverage is desired for travel in aircraft owned or leased by your company, please complete Aircraft Report (PA-1755-7 NY) and Pilot History (PA-1754-6 NY) and attach both forms to this questionnaire.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_  
Agent's name \_\_\_\_\_ Agent's Code \_\_\_\_\_ Date \_\_\_\_\_