Group Benefits from The Hartford

Pre-Schooler Accident Program

Request for Insurance (Countrywide)

❒ New Business　　Underwriting Company　Hartford Life and Accident Insurance Company

❒ Renewal of Policy No. ______________________

Coverage will become effective on the date requested if your Request for Insurance is received and approved by the Company's issuing office prior to that date. Otherwise, coverage will begin on the date your Request for Insurance is approved by the issuing office. No list of names is required. The minimum premium is $310

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1. Policyholder: ______________________

   Local Address of Policyholder: ______________________

   Address to be covered (if different): ______________________

2. Type of Group: ❒ Head Start ❒ Day Care Center ❒ Nursery School ❒ Kindergarten

   Type of Setting: ❒ Home ❒ Institutional

   Type of Coverage: ❒ Primary ❒ Excess

3. Accident Medical Expense Deductible requested: ❒ None ❒ $100

   ****Please refer to our website at www.accidentlines.com to acquire additional information regarding plans and rates****

4. General Information

   Number of Insured Persons

   Students up to age 7 __________

   Students age 7 and above (after school only)

   Teachers and Supervisors to be covered ❒ No ❒ Yes Number:

   Per Person Rate: $ __________

   Total Policy Premium: $ __________

   Effective Date: __________ Expiration Date: __________

5. Previous Insurance - If you have carried Pre-Schooler Accident Insurance in the past, please give the following details for the past three years.

Policy Year	20______	20______	20______
Total Premium	$______	$______	$______
Total Incurred Claims	$______	$______	$______
Total Number of Claims	______	______	______

Name of prior carrier:

Be sure to include a copy of the current policy or certificate. No business can be considered where annual premium is $500 or more unless this information is completed.

❒ Check here if no prior coverage

Insurance Requested by: ______________________ Title: __________ Date: __________

REQUIRED INFORMATION:

Name of Agent ______________________ Agency Code __________ License no. __________

Address: ______________________

Signature of Licensed Resident Agent (where required) ______________________

Sub-Producer (Agent) Name: ______________________ License no. __________

Must be Life and Health appointed. Appointment application and license copy for Agent and Sub-Producer required.

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Expertise without equal.
Benefits without burden.SM