

Group Benefits from The Hartford

# Pre-Schooler Accident Program

## Request for Insurance (New York)



New Business Underwriting Company Hartford Life 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 \$250

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  \$30

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**\*\*Please refer to our website at [www.accidentlines.com](http://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: \$ \_\_\_\_\_

#### 5. If over 100 persons will be insured, show previous loss experience:

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.

2910 (07/08)

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