

# Special Risk Accident Program

## Request for Insurance (Enhanced)



New Business Underwriting Company  Hartford Life and Accident Insurance Company  
 Renewal of Policy No. \_\_\_\_\_

If a policy is requested or if a quotation is requested and subsequently accepted by the organization, insurance will commence on the later of: (a) desired effective date, (b) the date the request for policy is accepted by the Company, or (c) the date the organization accepts the quotation. THE MINIMUM POLICY PREMIUM IS \$310.00. For additional underwriting information please refer to our website at [www.accidentlines.com](http://www.accidentlines.com)

- Name of Proposed Insured: \_\_\_\_\_
- Address: \_\_\_\_\_
- Name of Sponsoring Organization, if any: \_\_\_\_\_
- Period of Coverage Desired (date): \_\_\_\_\_

### 5. Type and Amount of Benefit (Check Amounts Desired)

Accidental Death Maximum Benefit  \$500;  \$1,000;  \$2,500;  \$5,000;  \$10,000;  Specify Other \$ \_\_\_\_\_

Accidental Dismemberment Maximum Benefit  \$500;  \$1,000;  \$2,500;  \$5,000;  \$10,000;  Specify Other \$ \_\_\_\_\_

Accident Medical Expense Maximum Benefit  \$500;  \$1,000;  \$2,500;  \$5,000;  \$10,000;  Specify Other \$ \_\_\_\_\_

Deductible Amount  None;  \$ 25;  \$50;  Specify Other \$ \_\_\_\_\_

Dental Limit  \$50;  \$150;  \$250;  Specify Other \$ \_\_\_\_\_

Accident Total Disability Maximum Weekly Benefit  \$10;  \$25;  \$35;  \$50;  \$75;  Specify Other \$ \_\_\_\_\_

*(Check with your underwriting office to obtain benefit maximums and eligibility for your state.)*

Maximum Payment Period  13 Weeks;  6 Months;  1 Year;  2 Years;  Specify Other: \_\_\_\_\_

Waiting Period (Days)  1st Day;  8th Day;  15th Day;  Specify Other \_\_\_\_\_ Days

6. What experience do the participants and supervisors have in the activities to be covered? \_\_\_\_\_

### 7. Activities to be Covered: (Please be as specific as possible.)

Type of Activity	How Often Held	Number of Participants	Ages
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Are supervisors to be covered?  Yes  No Number \_\_\_\_\_

9. Is Travel coverage desired?  Yes  No

Specify:  Individual Travel (to and from activities) *Individual travel does not apply to all eligible groups.*  Group Travel (Travel as a member of a group)

If "Yes" indicate probable mode(s) of travel:  Scheduled Airline  Non-Scheduled Airline  Bus  Train  Private Auto

Other (Describe) \_\_\_\_\_

If air travel exposure in excess of \$250,000 is contemplated, check this box and submit full details to your Hartford Agent.

10. Excess Coverage  Yes  No

11. Describe fully all pertinent facts not specified (use separate sheet if necessary) \_\_\_\_\_

### 12. If a similar insurance program has been carried in the past, please give the following details for the past three years

Policy Year	20 _____	20 _____	20 _____	
Total Premium	\$ _____	\$ _____	\$ _____	Name of prior carrier _____
Total Incurred Claims	\$ _____	\$ _____	\$ _____	Be sure to include a copy of the current policy.

13. Signature of person providing this information: \_\_\_\_\_

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.