

Group Benefits from The Hartford

Special Risk Accident Program
Request for Insurance (New York)



Underwriting Companies: Hartford Life Insurance Company
New Business
Renewal of Policy No.

If a policy is requested or if a quotation is requested and subsequently accepted by the organization, insurance will commence of 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 \$250.00.

- 1. Name of Proposed Insured:
2. Address:
3. Name of Sponsoring Organization, if any:
4. 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
Accident Total Disability Maximum Weekly Benefit \$10; \$25; \$35; \$50; \$75; Specify Other
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.)

Table with 4 columns: 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)

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.

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Expertise without equal.
Benefits without burden. SM