

Group Benefits from The Hartford
Sports Accident Program
 Request for Insurance (New York)



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

Coverage will commence on the desired effective date or on the date your Request for Insurance is approved by the Company, whichever is later. The minimum premium is \$250.

1. Policyholder Name: _____
2. Policyholder Address: _____
3. Effective Date _____ Expiration Date _____
4. Please check here if Accident Medical Expense Benefit is desired on an Excess Basis over and above other insurance.
5. Sport(s) to be covered (Use additional sheet, if necessary):

| Sport Played | Team Name | Date of First Scheduled Practice Session or Game | Sport End Date | Age Group (12 & Under 13 to 15 16 to 18) | No. of Players Managers and Coaches | X Ind* Prem. | = Team Prem. |
|--------------|-----------|--|----------------|--|-------------------------------------|--------------|--------------|
| | | | | | | \$ | \$ |
| | | | | | | \$ | \$ |
| | | | | | | \$ | \$ |
| | | | | | | \$ | \$ |
| | | | | | | \$ | \$ |
| | | | | | | \$ | \$ |

* Individual Premium is the sum of the Accident Medical Expense rate and the Accidental Death and Dismemberment rate. Please refer to our website at www.accidentlines.com to acquire additional information regarding plans and rates.

6. Coverage:
 - Accidental Death and Dismemberment \$ _____ Maximum Benefit
 - Accident Medical Expense \$ _____ Maximum Benefit
 - Deductible Amount \$ _____

7. Previous Insurance Yes No
 If a sports accident 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 | _____ | | |
| Total Paid Claims | _____ | | |
| Total Open Reserves | _____ | | |
| Total Number of Claims | _____ | | |
| Name of Prior Carrier | _____ | | |

No new business can be considered unless the above information is completed.
 Be sure to include a copy of the current policy or certificate.

8. Signature of Person Providing 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.