



4600 Cox Road Glen Allen, Virginia 23060-9817 Phone: (800) 431-1270 Fax Number: (804) 527-7915

Private School Accident Insurance Questionnaire

Name of School: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____ E-Mail Address: _____

What Sports are offered to your students in Grades 6-12? _____
(If any, please submit for a quote. The rates below may not apply.)

Insured persons are covered for Injury resulting from an Accident which occurs directly from: 1) activities that are scheduled, sponsored, or supervised by the policyholder; or 2) premises owned, leased, or borrowed by the policyholder; or 3) travel scheduled, sponsored, or supervised by the policyholder.

Previous insurance; Indicate premiums and losses on accident coverage for the past three years-

- Check here if no Accident Medical Coverage

Policy year:	20_____	20_____	20_____
Premium:	\$_____	\$_____	\$_____
Losses:	\$_____	\$_____	\$_____

If losses please submit questionnaire for quote.

Please select only one plan. Coverage is Excess, please submit for a quote for Primary Coverage.

				Annual Rate:	
		<u>Accident Medical Expense</u>	<u>AD&D Coverage</u>	<u>\$0 Deductible</u>	<u>\$100 Deductible</u>
Plan Desired:	Plan A	\$5,000	\$5,000	<input type="checkbox"/> \$5.68	<input type="checkbox"/> \$4.24
	Plan B	\$10,000	\$5,000	<input type="checkbox"/> \$6.03	<input type="checkbox"/> \$4.56
	Plan C	\$25,000	\$5,000	<input type="checkbox"/> \$6.39	<input type="checkbox"/> \$4.91

				Rate	Total Premium	
Number of Students:	Grades K-5	# _____	x	\$ _____	=	\$ _____
	Grades 6-8	# _____	x	\$ _____	=	\$ _____
	Grades 9-12	# _____	x	\$ _____	=	\$ _____

Desired Effective Date: _____ Total premium due \$ _____
Minimum premium \$350

For other Plan options please submit questionnaire along with coverage desired for a quote.

Applicant's signature: _____ Date _____

Agency Name: _____ Agent # _____

Street Address: _____ Agent Resident License # _____

City: _____ State: _____ Zip code: _____

Phone Number () _____ Fax Number () _____

Agents Signature: _____ Email Address _____

Fax questionnaire to (804) 527-7915 to be issued. Rates may vary in FL and WA. Coverage shall not be bound until the Company approves the applicant's completed questionnaire. The Company's receipt of premium does not bind coverage until the completed questionnaire is approved. In the event the Company does not approve your questionnaire, your premium payment will be refunded. Mail the original signed questionnaire along with a check for the total premium or \$350 minimum premium, whichever is greater. Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.