



MARKEL INSURANCE COMPANY

P.O. Box 2009, Glen Allen, Virginia 23058 Phone 1-800-431-1270 Fax 804-527-7915

Child Care Centers, Nursery Schools & Head Start Programs Accident Medical Application

Policyholder Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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

Type of Business: ___ Child Care Center ___ Nursery School ___ Head Start Program Desired Effective Date: _____

Describe activities outside normal child care: _____

Indicate premiums and losses on accident coverage for the past three years if applicable: Name of Carrier: _____

Policy Year	20_____	20_____	20_____
Premium	\$ _____	\$ _____	\$ _____
Losses	\$ _____	\$ _____	\$ _____

Submit for quote when there have been losses in the prior 3 years and/or sports and/or travel exposure.

For other Plan options of if in FL, NE, SC or WV, please submit for a quote.

Plan Desired:	Primary Coverage -	<u>Under 7</u>	<u>7 & Over</u>	Excess Coverage -	<u>Under 7</u>	<u>7 & Over</u>
Plan A - \$5,000 Accident Medical Expense						
\$5,000 Accidental Death & Dismemberment	<input type="checkbox"/>	<u>\$5.76</u>	<input type="checkbox"/>	<u>\$7.22</u>	<input type="checkbox"/>	<u>\$4.13</u>
					<input type="checkbox"/>	<u>\$5.17</u>
Plan B - \$10,000 Accident Medical Expense						
\$ 5,000 Accidental Death & Dismemberment	<input type="checkbox"/>	<u>\$6.12</u>	<input type="checkbox"/>	<u>\$7.67</u>	<input type="checkbox"/>	<u>\$4.39</u>
					<input type="checkbox"/>	<u>\$5.49</u>
Plan C - \$25,000 Accident Medical Expense						
\$ 5,000 Accidental Death & Dismemberment	<input type="checkbox"/>	<u>\$6.48</u>	<input type="checkbox"/>	<u>\$8.11</u>	<input type="checkbox"/>	<u>\$4.64</u>
					<input type="checkbox"/>	<u>\$5.81</u>

Please select only one plan.

<u># of Insured Persons</u>	<u>Annual Rate</u>	<u>Premium</u>
Students under Age 7 _____ x _____ =		\$ _____

Students Age 7 and Over _____ x _____ =	\$ _____
---	----------

Minimum Premium \$350
(Except in FL, NE, SC and WV)

Total Annual Premium due: \$ _____

Applicant's Signature _____ Date _____

Producer's Name _____ Agent Acct. # _____

Address _____ Agent Resident License # _____

Phone Number _____ Fax Number _____ E-Mail Address _____

Fax questionnaire to (804) 527-7915 to be issued. Rates may vary for 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.