



# MARKEL INSURANCE COMPANY

P.O. Box 3870, Glen Allen, Virginia 23058-3870 1-800-431-1270 Fax 804-527-7915

## Questionnaire for Accident Medical Group Activities

Name of Group or Organization: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business is set up as:  Individual  Corporation  Partnership  Organization  Joint Venture

Describe specific activities to be covered: \_\_\_\_\_

List all sports to be covered: \_\_\_\_\_

Total numbers per age group: Age 12 & under \_\_\_\_ Age 13-15 \_\_\_\_ Age 16 & 18 \_\_\_\_ Age 19+ \_\_\_\_

Is coverage desired for staff/supervisors?  Yes  No if yes total number of staff to be covered: \_\_\_\_\_

Period of time coverage is requested for: \_\_\_\_\_

Name of current Accident Medical carrier: \_\_\_\_\_

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

| Policy Year | 20____   | 20____   | 20____   |
|-------------|----------|----------|----------|
| Premium     | \$ _____ | \$ _____ | \$ _____ |
| Losses      | \$ _____ | \$ _____ | \$ _____ |

Plan Desired:  Plan A - \$5,000 Accident Medical Expense \$5,000 Accidental Death & Dismemberment  
 Plan B - \$10,000 Accident Medical Expense \$5,000 Accidental Death & Dismemberment  
 Plan C - \$25,000 Accident Medical Expense \$5,000 Accidental Death & Dismemberment

Deductive Option:  \$0  \$50  \$100  \$250

Coverage option desired:  Excess Accident Medical  Primary Accident Medical

Applicants Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Producer/Agency Name: \_\_\_\_\_ Agent Number: \_\_\_\_\_

Address: \_\_\_\_\_ Agent Resident License # \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

Fax questionnaire to (804) 527-7915 to be quoted. 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. 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.