



# MARKEL INSURANCE COMPANY

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 must be either all Primary or all Excess.**

**Annual Rate Participant**

|               | <u>Accident Medical Expense</u> | <u>AD&amp;D Coverage</u> | <u>\$0 Deductible</u> |                                 | <u>\$100 Deductible</u>         |                                 |                                 |
|---------------|---------------------------------|--------------------------|-----------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
|               |                                 |                          | Primary               | Excess                          | Primary                         | Excess                          |                                 |
| Plan Desired: | Plan A                          | \$5,000                  | \$5,000               | <input type="checkbox"/> \$7.93 | <input type="checkbox"/> \$5.68 | <input type="checkbox"/> \$5.91 | <input type="checkbox"/> \$4.24 |
|               | Plan B                          | \$10,000                 | \$5,000               | <input type="checkbox"/> \$8.43 | <input type="checkbox"/> \$6.03 | <input type="checkbox"/> \$6.36 | <input type="checkbox"/> \$4.56 |
|               | Plan C                          | \$25,000                 | \$5,000               | <input type="checkbox"/> \$8.92 | <input type="checkbox"/> \$6.39 | <input type="checkbox"/> \$6.85 | <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.