



# MARKEL INSURANCE COMPANY

## Questionnaire for Accident Medical for Youth Sports Activities

Named of Group or Organization: \_\_\_\_\_

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

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

Business is set up as:  individual  corporation  partnership  organization  joint venture

\*\*\*\*Please complete the attached Sports Census for Listing of Sports and Number of Participants\*\*\*\*

Is coverage desired for coaches & managers?  Yes  No Total Number: \_\_\_\_\_

Date of actual season - Starting date: \_\_\_\_\_ Ending date: \_\_\_\_\_

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: \$\_\_\_\_\_ \$\_\_\_\_\_ \$\_\_\_\_\_

### Benefit Options:

- Plan A  \$5000 Accident Medical Expense/\$5000 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

Deductible chosen:  No deductible  \$100 deductible  
 \$50 deductible  \$250 deductible

Excess Accident Medical Coverage

Person Completeing Questionnaire: \_\_\_\_\_

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

Producer/Agency Name: \_\_\_\_\_

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

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

