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# Accident Medical Application

Child Care Centers, Nursery Schools, Head Start Programs and Montessori Schools.

Proposed Policyholder Name \_\_\_\_\_

Street Address \_\_\_\_\_

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

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Business Type  Individual  Corporation  Partnership  Other \_\_\_\_\_

Profit  Nonprofit

Child Care Center no camp  Child Care Center with camp  Montessori  Nursery School  Head Start

Other \_\_\_\_\_

Proposed Effective Date \_\_\_\_\_

Proposed Expiration Date \_\_\_\_\_

Plan Chosen  Plan 1 (C1)

Plan 4 (C4)

Term of Coverage  Annual Term

9-Month Term

## Number of Insured Persons

Students under Age 7 \_\_\_\_\_ x \_\_\_\_\_ rate = \$ \_\_\_\_\_

Students Age 7 and over \_\_\_\_\_ x \_\_\_\_\_ rate = \$ \_\_\_\_\_

Total Number of Insureds \_\_\_\_\_ \$ \_\_\_\_\_

Total Premium  
(\$350 Minimum Earned Premium)

## Premium & Loss History Past 3 Years:

Policy Year \_\_\_\_\_

Total Premium \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Total Incurred Claims \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Number of Claims \_\_\_\_\_

Name(s) of Insurance Carrier(s) \_\_\_\_\_

Check here if no prior coverage.

Coverage shall not be bound until the Company approves the applicant's completed application and full premium payment is received. The Company's receipt of premium does not bind coverage until the completed application is also approved. In the event the Company does not approve your application, your premium payment will be refunded.

**FAIR CREDIT REPORT ACT NOTICE**—An investigative consumer report may be requested by the insurer to which this application is assigned as to the consumer's character, general reputation, personal characteristics, and mode of living. Subsequent consumer reports may be requested in connection with an update or renewal, or extension of the insurance which this application is made. The applicant will be informed of the name and address of the consumer reporting agency that furnished the report.

**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.**

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Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_

Producer's Name \_\_\_\_\_

Street Address \_\_\_\_\_

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

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