Participant Accident Insurance Request for Quote Form

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Requested Effective Date of Coverage ____________________ Quote Due Date ____________________

Client Information

Name ____________________

Contact ____________________ Email ____________________

Address ____________________ City ____________________

State ____________ Zip Code ____________ Website ____________________

Risk Information

Type of Group

☐ Camp   Day Participants ____________ Overnight Participants ____________

☐ Non-Profit   ☐ Sports *(Identify)* ____________________

☐ Child Development/Daycare   ☐ Volunteer   ☐ Students

☐ Other *(Identify)* ____________________

Total Number of Participants ____________________

If applicable, Number of Participants by Age

12 & Under ____________ 13-15 ____________ 16-18 ____________ 19 & Above ____________

Maximum Age ____________________

Description of Covered Persons *(Who is to be covered)*

Describe Covered Activities

	Yes	No
Travel To/From	☐	☐

Desired Benefits

Accidental Death $ ____________________

Accidental Dismemberment $ ____________________

Accidental Paralysis $ ____________________

Accidental Medical Expense $ ____________________

☐ Excess   ☐ Primary

Maximum Benefit Period   ☐ 52 Weeks   ☐ 104 Weeks

Other Benefits Requested

Aggregate Limit per Occurrence *(Standard is 10 times the Accidental Death Benefit)* $ ____________________

Prior Coverage

	Yes	No
Is there a plan currently in-force?	☐	☐

If yes, Carrier Name ______________________________ Effective Date ____________________

Please provide us with a copy of the current effective policy, premium, and loss history for the last three years.

Producer Information

Name of Agency ____

Name of Contact ____

Street Address ____

City ______________________________ State ____________ Zip Code ________________

Phone Number ______________________________ Email ______________________________

Requested Commission *(15% is standard)* ______________________________

	Yes	No
Are you a licensed A&H producer in the applicable risk state(s)?	☐	☐
Are you an appointed producer with Great American Insurance Company?	☐	☐

I hereby acknowledge that all answers and statements contained on this form and any attachments are complete and accurate. I also understand that no coverage will become effective until an application has been approved by the Company.

Signature ____ **Date** ____________________

Submit