



APPLICATION FOR: Day Care/Preschool Accident Insurance

Policyholder Information

Policyholder Name: _____
Mailing Address: _____
Contact Name: _____ Phone Number: _____
Contact Email Address: _____ Insured Email Address: _____

Plan and Benefits

Effective Date: _____ Expiration Date: _____
Maximum Medical Expense Benefit: \$ _____
Accidental Death & Dismemberment Principal Sum: \$ _____
Deductible (per claim) \$ _____
Type of Coverage: [] Excess [] Primary
Coverage for: [] All Enrollees and Staff of the Policyholder [] All Enrollees of the Policyholder
Number of Enrollees to be Insured: _____ Number of Staff to be Insured: _____

Prior Coverage

Have you had prior coverage? [] Yes [] No
What was your current annual policy year enrollment: _____ Premium: \$ _____
Has coverage ever been declined or cancelled due to losses? [] Yes [] No

Declaration and Signature

[] Applicant declares information provided is true and that no material facts have been suppressed or misstated.
[] Applicant understands false statements or misrepresentations may result in termination of this insurance contract.

Authorized Signature _____ Date _____
Printed Name _____ Title _____

Email completed application to: jlynch@aliverisk.com

Agent Data

Agent Name: _____ Agency: _____
Address: _____ City/State/Zip: _____
Phone: _____ License Number: _____ Email: _____
Signature: _____ Date: _____

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