



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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