



APPLICATION FOR: Fair Volunteer Group Accident Insurance

Fair / Festival / Event Name: \_\_\_\_\_
Facility Name: \_\_\_\_\_
Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_
Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_
Contact Email Address: \_\_\_\_\_ Insured Email Address: \_\_\_\_\_
Describe Volunteer Activities: \_\_\_\_\_

Accident Medical Coverage
100% Usual & Customary Plan Benefits\*
Dental Benefit Included
\$2,500 Physical Therapy Benefit
Full Excess

Table with 2 columns: Benefits and Premium Calculation. Rows include Medical Expense Benefit Maximum per injury, Accidental Death & Dismemberment, Deductible, Number of Volunteers, X \$3.00 Premium Each, Policy Fee, and Total Due.

Minimum Premium and fee is \$375. If premium is less, you must pay \$375.

Table with 2 columns: Benefits and Premium Calculation. Rows include Medical Expense Benefit Maximum per injury, Accidental Death & Dismemberment, Deductible, Number of Volunteers, X \$4.50 Premium Each, Policy Fee, and Total Due.

Minimum Premium and fee is \$575. If premium is less, you must pay \$575.

Table with 2 columns: Benefits and Premium Calculation. Rows include Medical Expense Benefit Maximum per injury, Accidental Death & Dismemberment, Deductible, Number of Volunteers, X \$6.00 Premium Each, Policy Fee, and Total Due.

Minimum Premium and fee is \$675. If premium is less, you must pay \$675.

\*Coverage is \$100 primary/excess in states GA, IL, IN, MA, NH. Coverage is not available under this plan in KS, MD, MN, MO, OR, SD. Ask agent about coverage in these states.

Applicant Signature

By signing below, Applicant understands that the information provided in this document is intended to be a summary of coverage only. Complete coverage details are provided in the insurance policy and available upon request. 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. I understand Coverage is not in effect until coverage is accepted by the Insuring Company and binder has been provided to me.

Authorized Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Title \_\_\_\_\_

**Agent Information**

Agent Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_