



APPLICATION FOR: **Volunteer 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 Volunteers of the Policyholder

Number of Enrollees to be Insured: _____ Number of Staff to be Insured: _____

Types of activities the volunteers are performing? _____

Prior Coverage

Have you had prior coverage? Yes No

What is the current number of volunteers? _____ Premium: \$ _____

Has coverage ever been declined or canceled 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

Agent Data

Agent Name: _____ Agency: _____

Address: _____ City/State/Zip: _____

Phone: _____ License Number: _____ Email: _____

Signature: _____ Date: _____