ALIVE RISK

APPLICATION FOR: **Business Travel Accident Questionnaire**

Submission Date: _____ Due Date: _____ Requested Effective Date: _____

RISK INFORMATION

Organization Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Do you currently have Business Travel Accident coverage? ☐ Yes ☐ No

If yes, please provide a copy of your policy's schedule page.

TRAVEL ASSESSMENT

Please complete the chart below based on your current coverage. If changes are desired, please indicate where applicable. Attach a separate sheet of paper if additional room is needed.

	Class 1	Class 2	Class 3	Class 4
Class Description (i.e. Managers, Sales, All Employees)				
Benefit Amount				
Type of Coverage (Business Travel Only, Business and Pleasure or Full Occupational)				
Total Number of Insureds				
Number of Insureds who travel on Business Over 50 days per year*				
26-50 days per year*				
10-25 days per year*				
1-9 days per year*				
0 days per year*				
Number of truck drivers, chauffeurs, and/or delivery men				
Number of Company Cars				
Average Salary of Travelers				

***Any time away from the office (business lunches, client visits, etc.) is considered a day of travel.**
****If salary is used to determine the benefit for a Class, please attach a salary census for all the insureds in that Class.**

BENEFITS

Additional Benefits Available*:

☐ Kidnap & Extortion Consultant Expense ($50,000 maximum)

☐ Security Evacuation (100% of Usual & Customary Expenses)

☐ Identity Theft Expense ($1,000) /Loss of Travel Documents ($1,000)

☐ Out of Country Medical

☐ Other (Describe): _____

*If any of the above benefits are to be included, or if there is international travel, then the long version of the Business Travel Accident Questionnaire must be completed.

AGGREGATE LIMIT

What Aggregate Limit of Indemnity is required: $_____ Per _____ Accident
$_____ Per Aircraft Accident

AFFILIATED COMPANIES/SUBSIDIARIES

List Affiliated Companies/Subsidiaries to be included under this program and their nature of business. Remember to include the Affiliated Companies' travel exposure in the Travel Assessment above. _____

_____

_____

COMPANY AIRCRAFT

Does your company own, operate, or lease any aircraft? ☐ Yes ☐ No

If yes, please complete the chart below.

Year	Make & Model	FAA or Serial #	Crew Seats	Passenger Seats	Avg. Occupancy	Avg. Usage

Do you wish to cover employee pilots? ☐ Yes ☐ No

If yes, please list their names and their respective type of pilot license.

Name	Type of Pilot License

WAR RISK COVERAGE

Is War Risk Coverage* desired? ☐ Yes ☐ No

If yes, please complete the chart below.

Visited Country	Length of Stay	Average Number of Trips

*War or act of war is a standard exclusion on Travel Accident policies. In order to have coverage for losses resulting from war or acts of war, War Risk Coverage must be purchased.

PRODUCER INFORMATION

Producer Name: _____ Producer Code: _____

Contact Person: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

E-mail Address: _____ Web Address: _____

Requested Commissions: _____ Broker of Record? ☐ Yes ☐ No

Are you a licensed Accident & Health Producer in the applicable risk state? ☐ Yes ☐ No

State License Number: _____ National License Number: _____