ALIVE RISK

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

Agent Data

Agent Name: _____ Agency: _____

Address: _____ City/State/Zip: _____

Phone: _____ License Number: _____ Email: _____

Signature: _____ Date: _____

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