



PO Box 3870, Glen Allen, VA 23058-3870
(804) 527-2700 (800) 900-1155 Fax (804) 273-6144
www.markelinsurance.com

Social Services Excess
Accident Medical Application

Name of Insured: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Business is: [] Corporation [] Individual [] LLC [] Partnership [] Organization

Policy Effective Date: ____/____/____ Coverage will be: [] Annual [] Time Period _____

Please describe activities to be covered: _____

Name of your current Accident Medical carrier: _____

[] Please check here if no prior Accident Medical Coverage was provided.

Please indicate premiums and losses on accident coverage for the past 3 years:

Policy Year: _____
Premium: \$ _____ \$ _____ \$ _____
Losses: \$ _____ \$ _____ \$ _____

Is coverage desired for: (Note: All members in each of the following groups must be included.)

Paid staff/supervisors? [] Yes [] No Total Number: _____
Volunteer Workers? [] Yes [] No Total Number: _____
Clients? [] Yes [] No Total Number: _____

Please provide the number of clients/participants in the following age groups:
Ages 13 & Under: _____
Ages 14 - 18: _____
Ages 19 & Over: _____

Plan Desired: [] SR Plan 11 (SK) \$5,000 Accident Medical Expense/\$5,000 Accidental Death & Dismemberment
[] SR Plan 16 (SP) \$10,000 Accident Medical Expense/\$10,000 Accidental Death & Dismemberment

Note: Coverage is excess over any expenses payable by other similar valid and collectible insurance.

Producer/Agency Name: _____

Address: _____

Phone: (____) _____ Fax #: (____) _____

E-mail Address: _____

Premium Payment: Coverage shall not be bound until the Company approves the applicant's completed questionnaire and premium payment is received. The Company's receipt of premium does not bind coverage until the completed application is approved. In the event the Company does not approve your application, your premium payment will be refunded.

Fair Credit Report Act Notice: An investigative consumer report may be requested by the insured to which this application is assigned as to the consumer's character, general reputation, personal characteristics and mode of living. Subsequent consumer reports may be requested in connection with an update or renewal, or extension of the insurance for which this application is made. The applicant will be informed of the name and address of the consumer-reporting agency that furnished the report.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and shall also be subject to a civil penalty, not to exceed five thousand dollars and the stated value of the claim for each such violation.

Insured's Signature: _____ Date: _____

Print Name: _____ Phone: (____) _____

Fax: (____) _____ E-mail: _____