MARKEL INSURANCE COMPANY

SOCIAL SERVICES EXCESS ACCIDENT MEDICAL APPLICATION

P.O. Box 3870, Glen Allen, VA 23058-3870
(800) 431-1270 Fax (804) 527-7966

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.

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

Fair Credit Report Act Notice: Personal information about you, including information from a credit or other investigative report, may be collected from persons other than you in connection with this application for insurance and subsequent amendments and renewals. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization. Credit scoring information may be used to help determine either your eligibility for insurance or the premium you will be charged. We may use a third party in connection with the development of your score. You have the right to review your personal information in our files and can request correction of any inaccuracies. A more detailed description of your rights and our practices regarding such information is available upon request. Contact your agent or broker for instructions on how to submit a request to us.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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 subjects the person to criminal and (NY substantial) civil penalties. (NOT APPLICABLE IN: CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA) (INSURANCE BENEFITS MAY ALSO BE DENIED IN LA, ME, TN, and VA.) For additional warnings, please visit:
http://www.markelinsurance.com/Applications/Pages/FraudWarnings.aspx

I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which would materially affect this insurance has been withheld.

Applicant's Signature: ____ Date: ______________

Producer Signature: ____ Date: _______________

Agency Name: ____

Agency Address: __________________________________ City/State/Zip ____