



# Camp Accident Medical Application

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

Camp Name: \_\_\_\_\_

Camp Administrator's Name: \_\_\_\_\_

Summer Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Summer Phone: (\_\_\_\_\_) \_\_\_\_\_ Winter Phone: (\_\_\_\_\_) \_\_\_\_\_

Winter Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Desired Policy Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Is the camp ACA accredited?  Yes  No Is the camp a member of CCCA?  Yes  No

2. Name of sponsoring organization (if any): \_\_\_\_\_

3. Type of Camp:  Organizational  Church  Private

Resident  Day  Weekend

4. Camp Open:  Five days  Six days  Seven days  Other:

5. Is this a sports camp?  Yes  No If yes, what sport? \_\_\_\_\_

6. Is this a specialty camp? (e.g. computer, disability serving)  Yes  No If yes, specify? \_\_\_\_\_

7. Number of camp doctors on premises: \_\_\_\_\_

8. Number of camp nurses on premises: \_\_\_\_\_

9. Previous Insurance: If a Camper insurance program has been carried in the past, please give the following details for the past 3 years. **(Note: This section is not required if coverage was previously carried with Markel Insurance Company.)**

No prior coverage:

Policy Year: \_\_\_\_\_

Premium: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Losses: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

10. Is staff to be covered?  Yes  No If yes, estimated number of staff per week: \_\_\_\_\_

11. Are volunteers to be covered?  Yes  No If yes, estimated number of volunteers per week: \_\_\_\_\_

12. What is the pre-camp arrival date for staff: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Departure Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
13. What is the camp opening date? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Camp Closing Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
14. What is the estimated number of campers per week? \_\_\_\_\_
15. What is the age range of campers? \_\_\_\_\_ (youngest) through \_\_\_\_\_ (oldest)
16. Check Desired Plan:

Plan-Primary (Check desired plan)	Accident Medical Expense	Accidental Death and Dismemberment	Primary Sickness Medical Expense	Catastrophe Cash	Aggregate
<b>Resident Camps</b>					
<input type="checkbox"/>	\$3,500	\$5,000	\$1,000	\$25,000	\$250,000
<input type="checkbox"/>	\$3,500	\$10,000	\$1,000	\$25,000	\$250,000
<input type="checkbox"/>	\$5,000	\$10,000	\$1,000	\$25,000	\$250,000
<input type="checkbox"/>	\$12,500	\$15,000	\$1,000	\$25,000	\$250,000
<b>Day Camps</b>					
<input type="checkbox"/>	\$3,500	\$5,000	\$0	\$25,000	\$250,000
<input type="checkbox"/>	\$3,500	\$10,000	\$0	\$25,000	\$250,000
<input type="checkbox"/>	\$5,000	\$10,000	\$0	\$25,000	\$250,000
<input type="checkbox"/>	\$12,500	\$15,000	\$0	\$25,000	\$250,000

**NOTES:** Catastrophe Cash not available in New York. Sickness Medical Expense not available in Washington and New Jersey.

**Special Conditions**

- \$350 minimum earned premium per policy on Mandatory Benefits.
- There is a \$0 deductible for all plans.
- The Insurance Company reserves the right to audit camp records.
- All pre-existing health conditions are excluded.

**Premium Payment:** 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 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.

\_\_\_\_\_  
Signature of Camp Administrator Date

\_\_\_\_\_  
Producer Name Producer's Phone #

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip