



SOCIAL SERVICES EXCESS ACCIDENT MEDICAL APPLICATION

P.O. Box 2009, Glen Allen, VA 23058-2009
(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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Total Number: _____
Volunteer Workers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Total Number: _____
Clients?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____