CHILD CARE CENTERS, RELIGIOUS ORGANIZATIONS AND VOLUNTEERS ACCIDENT MEDICAL INSURANCE PROGRAMS

PHLY Marketing Representative:

QUOTE REQUEST FORM

Enrollment form must be completed and returned for underwriter review. Submission of this form does not guarantee coverage. Quote will be offered if risk meets Underwriting Guidelines. Payment of premium is Named Insured's formal request to obtain insurance through the Special Markets Accident Medical Insurance Program.

ACCOUNT INFORMATION

Named Insured ____
(as to be shown on policy declarations page)

Mailing Address ______________________________ Email ____________________

City ____________________________ State ______________ Zip ______________

Fax ________________________ Website ____________________________________

Physical Address ____

Contact Person __________________ Title ____________________ Phone ______________

Effective Date ______________________ Expiration Date __________________________

Activity Start Date __________________ Activity End Date __________________________

Please use additional sheet to list Activity Start & End Dates if more than one Activity is held.

Named Insured is: ❑ Individual ❑ Partnership ❑ Corporation ❑ Association ❑ Other:__________ ❑ Non Profit

Years this entity in business__________________ Years experience for this owner __________________

COVERAGE REQUESTED:

Accident Medical Limits	❑ $25,000			
Deductible Limits	❑ $0	❑ $100	❑ $250	❑ $500
Coverage Type	❑ Full Excess		❑ Primary Excess	
	If Primary Excess, what amount		❑ $100 ❑ $300	❑ $500

TYPE OF ORGANIZATION ❑ League ❑ Team ❑ Association ❑ All Star Game/Tournament
❑ Day Camp/Clinic _____ # of Days ❑ Overnight Camp/Clinic _____ # of Days ❑Other__________________

Sport / Activity	Age(s)	Number of Participants
______________________	Ages 12 & Under	________________
______________________	Ages 13 – 15	________________
______________________	Ages 16 – 18	________________
______________________	Ages 19 & up	________________
______________________	Coaches	________________
______________________	Officials/Umpires	________________
______________________	Volunteers	________________

For Activities other than Sports, please provide a brief description of activities to be covered.

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UNDERWRITING INFORMATION

Do you currently have Accident Coverage?

1. Do you currently have Accident Medical Coverage? ❑ Yes ❑ No
   a. If yes, please provide a copy of your current policy's schedule page.

PRIOR INSURANCE INFORMATION

Provide minimum three years information.

Year	Company	Type of Claim	Claim Amount

For Reporting Purposes only:

Is the General Liability coverage being placed with Philadelphia Insurance Companies? ❑ **Yes** ❑ **No**

PLEASE RETURN FORM TO:

Special Markets Insurance Consultants, Inc.
2615 Post Road
Stevens Point, WI 54481
Phone: (800) 727-7642 ♦ Fax: (715) 344-6126
Email: info@specialmarkets.com

FRAUD STATEMENT (Not applicable in Colorado, Florida, New Jersey, & Virginia)
Any person who knowingly & with intent to defraud any insurance company or other person files an application for insurance or settlement 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 such person to criminal and (New York: substantial) civil penalties. In Maine and Virginia, insurance benefits may be denied and penalties include imprisonment and fines.

Applicant's Statement and Declarations

The applicant declares to the best of his / her knowledge the information contained in this application and all supplements attached to be true and that no material facts have been suppressed or misstated. The applicant further understands that any false or fraudulent statements or misrepresentations could result in termination or voidance of any insurance contract issued from the information stated herein.

Authorized Signature______________________ **Date**______________________

Printed Name ______________________ **Title**______________________

All above information requested is required for policy issuance. The licensed appointed agent is required to complete the section below. Policies can not be issued without all the required information being completed.

Local/Regional Licensed Agency

Agency Name: ______________________ License Number: ______________________

Agent Name (Printed): ______________________ Agent Address: ______________________

City, State, Zip: ______________________ Phone Number: ______________________

Signature: ______________________ Date: ______________________
(Licensed Agent)

Email Address: ______________________ Proposal Number: ______________________