

# Volunteer Accident Insurance Program



## Enrollment Form

Print or Type. If question is not applicable, indicate N/A.

### Producer Information

Broker/Agency \_\_\_\_\_

Contact Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

### Policyholder Information

Name \_\_\_\_\_

Address \_\_\_\_\_

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

List address(es) of facility (facilities) to be covered \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Type of organization:

State government     Municipality     Nonprofit     Other (describe) \_\_\_\_\_

Type of facility:

Office     Library     Park/recreation area     Hospital     Other (describe) \_\_\_\_\_

### Choice of Insurance

The premium rates shown below are per person per year.

Choose the program you want:

Program 1     \$1.75

Program 2     \$3.25

Program 3     \$3.50

Choose a WAI Option if you wish:

WAI Option A     \$1.00

WAI Option B     \$2.00

### Premium Calculation

Number of volunteers utilized per year \_\_\_\_\_

x rate per person per year (include WAI if applicable) \$ \_\_\_\_\_

Total premium \$ \_\_\_\_\_

The minimum total premium is \$300. 100% participation is required.

### Requested Policy Effective Date

Coverage becomes effective on the requested date assuming the Insurance Company has accepted the risk and received the attached enrollment form on or before the requested effective date. If the enrollment form is not received by the requested date, the effective date will be the date the Insurance Company receives the enrollment form. Please enter the effective date in the spaces below. The coverage period is one (1) year from the policy effective date.

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

### Previous Insurance

If an Accident Insurance program has been in force, please give full details for the past three (3) years:

Policy year	_____		_____		_____	
Total premium	\$	_____		_____		_____
Total paid claims	\$	_____		_____		_____
Number of claims	_____		_____		_____	
Name(s) of previous carrier(s)	_____					
	_____					
	_____					

Check here if no prior coverage

### Signed Statement

The above is correct to the best of my knowledge. I understand that the Insurance Company must approve my enrollment form before coverage is effective and may audit my records to verify proper payment.

By signing below, I acknowledge that I have read, understand and agree to the terms and conditions of this coverage as presented in this brochure.

Officer's name (print) \_\_\_\_\_

Signature \_\_\_\_\_

Title (print) \_\_\_\_\_

Date \_\_\_\_\_

After completing both sides of this enrollment form, return it to your local Accident & Health Office.