214 Key Drive, Suite 2000
Madison, MS 39110
Phone: 866-386-4136
Fax: 601-898-4793
Email: cs@continentalbrokers.biz

Questionnaire for Accident Medical Group Activities

Name of Group or Organization: ____

Mailing Address: ____

City: ____ **State:** ____________ **Zip:** ______________

Business is set up as: ___ individual ___corporation ___partnership ___Organization ___ joint venture

Describe specific activities to be covered: ____

List all sports to be covered: ____

Age of the group and number of each: Age 13 & Under ______ Age 14-18 _____ Age 19 & over _____

Is coverage desired for staff/supervisors? ___Yes ___No if yes total number of participants: ________

Period of time coverage is requested for : ____

Name of current Accident Medical carrier: ____

Previous insurance: Indicate premiums and losses on accident coverage for the past three years:

Policy Year	**20___**	**20___**	**20___**
Premium	**$_________**	**$________**	**$________**
Losses	**$________**	**$________**	**$________**

Plan Desired:
Plan A __ $5000Accident Medical Expense $5000 Accidental Death & Dismemberment
Plan B __ $10000 Accident Medical Expense $5000 Accidental Death & Dismemberment
Plan C __ $25000 Accident Medical Expense $5000 Accidental Death & Dismemberment

Deductive Option: __$0 __$50 __$100 __$250

Coverage option desired: ____ Excess Accident Medical ___Primary Accident Medical

Applicants Signature: ____**Date:** ___________________________

Producer/Agency Name:_______________________________________ **Agent Number :**_________________

Address: ____ _______________________

Email Address: ____

Phone Number: ( ) _______________________ **Fax Number:** ( ) ______________________