ALIVE RISK
A DIVISION OF ALL RISKS, LTD.

APPLICATION FOR: Fair Volunteer Group Accident Insurance

Fair/Festival/Event Name: _____

Facility Name: _____

Street Address: _____ City/State/Zip: _____

Contact Name: _____ Phone Number: _____

Contact Email: _____ Insured Email: _____

Describe Volunteer Activities: _____

_____

_____

_____

Accident Medical Coverage
100% Usual & Customary Plan Benefits*
Dental Benefit Included
$2,500 Physical Therapy Benefit
Full Excess

Benefits		Premium Calculation	
$25,000	Medical Expense Benefit Maximum per injury	Number of Volunteers:	_____
$5,000	Accidental Death & Dismemberment	X $3.00 Premium Each =	$ _____
Deductible	$100 per injury	Policy Fee =	$75.00
		Total Due =	$ _____

Minimum Premium & fee is $375. If premium is less, you must pay $375.

Benefits		Premium Calculation	
$50,000	Medical Expense Benefit Maximum per injury	Number of Volunteers:	_____
$10,000	Accidental Death & Dismemberment	X $4.50 Premium Each =	$ _____
Deductible	$100 per injury	Policy Fee =	$75.00
		Total Due =	$ _____

Minimum Premium & fee is $575. If premium is less, you must pay $575.

Benefits		Premium Calculation	
$100,000	Medical Expense Benefit Maximum per injury	Number of Volunteers:	_____
$15,000	Accidental Death & Dismemberment	X $6.00 Premium Each =	$ _____
Deductible	$100 per injury	Policy Fee =	$75.00
		Total Due =	$ _____

Minimum Premium & fee is $675. If premium is less, you must pay $675.

*Coverage is $100 primary/excess in states GA, IL, IN, MA, NH. Coverage is not available under this plan in KS, MD, MN, MO, OR, SD. Ask agent about coverage in these states.

Applicant Signature

By signing below, Applicant understands that the information provided in this document is intended to be a summary of coverage only. Complete coverage details are provided in the insurance policy and available upon request. Applicant declares information provided is true and that no material facts have been suppressed or misstated. Applicant understands false statements or misrepresentations may result in termination of this insurance contract. I understand Coverage is not in effect until coverage is accepted by the Insuring Company and binder has been provided to me.

Authorized Signature: _____ Date: _____

Printed Name: _____ Title: _____

Agent Information

Agent: _____ Agency: _____

Address: _____ City/State/Zip: _____

Phone: _____ Email: _____