Global UNDERWRITERS

ACCIDENT & HEALTH

Group Special Risk Accident Application

Submission Date: ______________________
Quote Due Date: ______________________
Req. Effective Date: ______________________

CLIENT INFORMATION

Name/Policyholder: ______________________

Street Address: ______________________

City: ______________________ State: ____________ Zip Code: ________

Nature of Association: ______________________

Web Address: ______________________

Date of Formation: ______________________

Is coverage being sought specifically for U.S. members? ❒ Yes ❒ No

PRIOR COVERAGE

Is there an insurance plan currently in-force? ❒ Yes ❒ No

If "Yes", what is the Effective Date? ______________________

If "Yes", why is the association looking for a new carrier or product? ______________________

If "Yes", please provide us with a copy of the current in-force policy and the premium and loss history for the last three (3) years. Also, please include a copy of most recent monthly premium report.

Please give a very specific description of the type of coverage(s) being sought.

RISK DATA

Is the Policyholder a bona fide: Association* ❒ Labor Union ❒

**If Policyholder is a bona fide "Association", please include a copy of the constitution and by-laws as well as a membership brochure.*

What are the annual membership dues? ______________________

Total Number of Members: ______________________

Total Number of Members to be Covered: ______________________

Total Potential Members: ______________________

What is the demographic profile of the typical member? ______________________

____

Describe each class to be covered:

Class 1: ______________________

Class 2: (if applicable) ______________________

Class 3: (if applicable) ______________________

Amounts of Accidental Death & Dismemberment Insurance Requested $ ______________________

Please provide the following information as attachments:

- The geographic distribution of the members
- A list of the number of members by state
- A breakdown of the distribution of members by age

Check all additional benefits in the plan design you wish to include.

❒ Common Accident
❒ Enhanced Benefit for Dependent Children
❒ COBRA Premium Continuation
❒ Felonious Assault
❒ TTD
❒ Child Care Expense
❒ Spouse Employment Training
❒ Paralysis
❒ Psychological Therapy Benefit
❒ Burn Benefit
❒ Felonious Assault
❒ *Occupational Hepatitis
❒ In-Hospital
❒ Medical Evacuation and Repatriation
❒ Aircraft Pilot and Crew extension
❒ Owned/Leased aircraft extension
❒ Accident Medical Expense
❒ Education Expense
❒ Seat Belt
❒ Coma Benefit
❒ Rehabilitation Benefit
❒ Carjacking
❒ Home Alteration or Vehicle Modification
❒ *Occupational HIV

Not all benefits are available in all states.
**Occupational Hepatitis and Occupational HIV are only available to members of Health Care Associations*

ADDITIONAL QUESTIONS FOR ASSOCIATION PLANS

Please answer questions in space below or complete on a separate sheet and attach.

	YES	NO
1. If this is a bona fide association in the state that the Association is chartered or incorporated?	❐	❐
2. What other Association programs are major competitors for membership?		
3. Are there Local District, State, Regional or National Affiliates of the Association? Provide details? ______	❐	❐
4. Do any of these Affiliates offer Insurance coverage(s) to members of this Association? If Yes, list current programs ______	❐	❐
5. Is this a Sponsored Program? (The Association actively sponsors and manages the program or enlists an entity to do it on their behalf)	❐	❐
6. Is this an Endorsed Program? (The program has been vetted and approved by the Association but they are not active marketers of the program. Another entity holds the interest in marketing the program)	❐	❐
7. How many members participate in **EACH** insurance plan offered by the association? ______		
8. List all coverages and products being marketed/sold through the Association? (Inception Date, No. of Insured's, percent of participation, insurer, broker/agent, or marketing organization)		
9. How are products being marketed? Provide copies of screen shots for periodicals, newsletters, the web, used to market the coverage's.		
10. Is there an annual convention/gathering? If yes, how many members attended the last convention? ______	❐	❐
11. Is there a Trust? If yes, please provide copy of Trust Agreement as well as an explanation of the purpose for which the trust was formed. ______	❐	❐
12. Please provide an in depth description of the administrative procedures; eg: Enrollment, Fulfillment, Billing, Customer Service, Claims, etc. If you have any partners providing these functions for you please indicate who they are and the responsibilities of each entity.	❐	❐
13. Are there administration agreements in place? If yes, please provide copies.	❐	❐
14. What is the rate of growth and turn over rates for the current plan(s)? Growth Rates ______ Turn Over Rates ______		
15. Please provide a history of different carriers you have worked with.		

LIST OF INCLUDED DOCUMENTS (Check all that apply)

- ❒ Constitution
- ❒ Copy of In-force or prior policy
- ❒ Claims Information
- ❒ Distribution of members by age
- ❒ Bylaws
- ❒ Marketing Materials
- ❒ Administration Agreement
- ❒ Other ______________________
- ❒ Membership Brochure
- ❒ Trust Agreement
- ❒ List of the number of members by state

PRODUCER/ORGANIZATION INFORMATION

Name: ____

Street Address: ____

City: ______________________ State: ______________ Zip Code: __________

Contact Name: ______________________ Phone Number: ______________________

Email Address: ______________________ Fax Number: ______________________

Requested Commission (%):

Are you licensed as: TPA? ❒ MGA? ❒

If you are an MGA how many sub-producers do you work with? ______________________

Please provide information on the geographical spread of your sub-producers. ______________________

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