



MARKEL INSURANCE COMPANY

P.O. Box 3870, Glen Allen, Virginia 23058-3870 1-800-431-1270 Fax 804-527-7915

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 \$5000 Accident 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: () _____

Agent Signature: _____