Arch Insurance, Accident & Health
T: 855 951 2328
accidentandhealth@archinsurance.com

Participant Accident Questionnaire

Quote Due Date: _____ Requested Effective Date: _____

Requested Expiration Date: _____

Client Information

Client Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Nature of Business: _____ SIC Code: _____

List All Entities To Be Covered, If Applicable: _____

Risk Information

Type of Group:

☐ Team ☐ Club ☐ League ☐ Not For Profit ☐ Employer ☐ Other: _____

Description of Insureds: _____

_____

Description of Activities: _____

_____

Age of Insureds: (List the number of insured by age group)

_____ Under 12 _____ 13-15 _____ 16-18 _____ Over 18 years of age

Total Number of Insured: _____

Amount of Total Exposure: (length of season, number of events, meetings, tournaments, etc.)

_____

_____

Plan Design & Benefit Limits

Accidental Death & Dismemberment:
(Enter amount between $5,000 and $250,000)

Amount: _____

Accidental Medical Expense Benefit:
(Enter amount between $1,000 and $100,000)

Amount: _____ ☐ **Excess** ☐ **Primary**

Deductible:
(Choose a deductible from $0 to $1,000)

Amount: _____

Other Benefit(s):
Please provide Type and Limit(s)

_____

Arch Insurance, Accident & Health
T: 855 951 2328
accidentandhealth@archinsurance.com

Unusual or Hazardous Exposures

Are there any known concentrations, unusual or hazardous exposures to be covered? ☐ **Yes** ☐ **No**

If Yes, please describe: _____

Are there any insureds whose duties take place in moving vehicles? ☐ **Yes** ☐ **No**

If Yes, please describe: _____

Are there any insureds whose duties regularly take place off-site? ☐ **Yes** ☐ **No**

If Yes, please describe: _____

Premium Remittance

How are premiums to be paid (i.e. annually, quarterly, monthly)? _____

Prior Coverage

If no prior coverage, check here: ☐

Please provide at least 3 years of Premium and Loss History. Additionally, please provide a copy of a summary plan description or policy, which will provide current eligibility and plan design.

Term	Earned Premium	Incurred Losses	Number of Losses

Agency/Broker/Consultant Information

Name of Firm: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Individual Contact: _____

Email: _____ Phone Number: _____

Requested Commission (15% unless otherwise noted and agreed upon): _____