Accident Insurance Program for Charity First

After completing this questionnaire, please email it to **CFsubmissions@charityfirst.com**.

PROPOSED PARTICIPATING ORGANIZATION INFORMATION

Proposed Participating Organization Legal Name: ____________________

Street Address: ____________________

City: ____________________ State: ____________________ ZIP: ____________

Phone: ____________________ FEIN Number: ____________________

Website Address: ____________________

TYPE OF ORGANIZATION

Charitable   Civic   Technical/Vocational/Business Schools   Educational Day Care   Recreational

Description of Covered Activities:

CHOICE OF COVERAGE

The premium rates shown below are per person per year.

Charitable, Civic and Recreational Groups Premium Rates Per Person Per Year	Plan 1	Plan 2
Volunteers	$2.95	$4.85
Participants	$3.90	$5.90

Educational Daycare Groups Premium Rates Per Person Per Year	Plan 1	Plan 2
Volunteers	$2.80	$4.30
Participants	$2.80	$4.30

Technical/ Vocational/ Business Schools Premium Rates Per Person Per Year	Plan 1	Plan 2
Volunteers	$3.20	$4.90
Participants	$4.90	$6.00

Plan Option Selected: Plan 1   Plan 2

PREMIUM CALCULATION

	Volunteers	Participants
Numbers utilized per year		
X rate per person per year	$	$
Total premium	$	$

The minimum non-refundable premium is $300 per policy per year. Coverage is mandatory for all volunteers and/or participants of the group.

PROPOSED COVERAGE EFFECTIVE DATE

Coverage becomes effective on the proposed date only if the insurance company has received the completed questionnaire and approved the risk on or before the proposed effective date. If the completed questionnaire is received after the proposed effective date, coverage will not take effect until the insurance company receives and accepts the questionnaire and approves the risk. Please enter the proposed effective date in the spaces below. The coverage period is one (1) year from the volunteer organization's effective date of coverage. ________ / ________ / ___________

APPROVAL

We will review the completed questionnaire promptly and notify you if coverage will be provided, or if there are any problems, miscalculations or omissions that would prevent us from issuing coverage.

PREVIOUS INSURANCE (RATES MAY VARY FROM THIS BROCHURE BASED ON PRIOR CLAIM HISTORY)

If an accident insurance program has been in force for your organization's volunteers, please give full details for the past three (3) years:

Policy year: ____________________ ____________________ ____________________

Total premium: $ ____________________ $ ____________________ $ ____________________

Total paid claims: $ ____________________ $ ____________________ $ ____________________

Number of claims: ____________________ ____________________

Name(s) of previous carrier(s): ____

____

Check here if no prior coverage (Upon review, more detail may be requested.)

SIGNED STATEMENT

All information on the questionnaire is correct to the best of my knowledge. I understand that the insurance company must accept and approve this questionnaire before coverage is effective. I agree that the insurance company may audit my records to verify proper payment. By signing below, I acknowledge that I have read, understand and agree to the terms and conditions of this coverage as presented in this brochure.

Officer's name (print) ____

Signature ____

Title (print) ________________________________ Date ____________________

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