

## K-12 Student Accident Insurance Request for Proposal

Coverage terms, conditions, limitations and exclusions may vary and may not be available in all states

|                                 |  |
|---------------------------------|--|
| Submission Date: _____          | When would you like to receive your quote? _____ |
| Requested Effective Date: _____ | Requested Commission: _____                      |

| Prospect Information  |  |                 |
|---|--|-----------------|
| Name: _____   |  |                 |
| Physical Address: _____   |  |                 |
| City: _____   | State: _____   | Zip Code: _____ |
| Telephone Number: _____   | Website: _____   |                 |
| Type of School: <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Charter | Number of Junior High Schools _____ High Schools _____ |                 |

| Student Participation and Covered Activities  |  |
|---|--|
| Requested Coverage:   | <input type="checkbox"/> Sports & School time <input type="checkbox"/> Sports Only <input type="checkbox"/> School time Only |
| Number of Students:   | K – Grade 8: _____ Grades 9-12: _____  |
| Number of Athletes:   | K – Grade 8: _____ Grades 9-12: _____  |
| Include Football/Ice Hockey coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes  | Number of Players: Junior High _____ High School _____   |
| Include Coverage for Spring or Summer Training/Camp? <input type="checkbox"/> No <input type="checkbox"/> Yes   |  |
| Include Coverage for Tryouts? <input type="checkbox"/> No <input type="checkbox"/> Yes  |  |
| Include Field Trip Coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes   |  |
| Additional Coverage (check all that apply): <input type="checkbox"/> Overnight Field Trips <input type="checkbox"/> Door to Door Travel <input type="checkbox"/> Activity Buses |  |

| Current Benefits Schedule   |   |
|---|---|
| <input type="checkbox"/> Accidental Death & Dismemberment* <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> Other \$ _____<br><small>Death or dismemberment loss must occur within 365 days of the accident.</small> |   |
| <input type="checkbox"/> Paralysis <input type="checkbox"/> Coma <small>The Paralysis and Coma principal sum amounts will be the same as the Accidental Death &amp; Dismemberment principal sum.</small>  |   |
| <input type="checkbox"/> Accident Medical Expense   |   |
| Benefit Maximum   | <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> Other \$ _____                     |
| Benefit Type  | <input type="checkbox"/> Full Excess <input type="checkbox"/> Primary <input type="checkbox"/> Other _____  |
| Deductible  | <input type="checkbox"/> Corridor <input type="checkbox"/> Vanishing (Integrated)   |
|   | <input type="checkbox"/> \$0 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> Other \$ _____ |
| Benefit Period  | <input type="checkbox"/> 52 weeks <input type="checkbox"/> 104 weeks <input type="checkbox"/> Other _____   |
| First expense must be incurred within:  | <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days of the Covered Accident  |
| Additional Requested Benefits: _____  |   |

**Current Coverage**

Insurance Company: \_\_\_\_\_

**Note:** Please attach a copy of the expiring policy.

Has the current plan design been the same over the past five (5) years?

☐ Yes ☐ No

If no, please describe the benefit/plan changes from year-to-year in detail: \_\_\_\_\_

**Premium and Loss History:** Please provide the premium and paid loss information for the past five (5) years. Be sure to include the validation date for the paid claim data (Note: The paid loss data should be within 60 days of the Submission Date of this request for proposal) and attach copies of the carrier loss runs that support the paid claims data.

Date through which claims are paid: \_\_\_\_\_

| Policy Year | Premium | Losses Paid | Deductible Amount | Student Count | Carrier |
|-------------|---------|-------------|-------------------|---------------|---------|
|             |         |             |                   |               |         |
|             |         |             |                   |               |         |
|             |         |             |                   |               |         |
|             |         |             |                   |               |         |
|             |         |             |                   |               |         |

**Producer Information**

Producer Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Agency Legal Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

**Note:** Business can only be bound, and commission payable, if you and your agency are properly licensed and appointed, by Berkley A&H, where required.

**Terms of Acknowledgement and Signature:** This Request for Proposal (RFP) is not a contract of insurance. No coverage is bound or afforded by this RFP. A proposal will be based on information included on or attached to this RFP. The undersigned hereby certifies that this information accurately represents the facts and that no requested information has been misrepresented, misstated, omitted, or altered. In the event that the undersigned becomes aware of facts that would have a material effect on the proposed coverage, any such facts or information must be immediately reported to carrier. I understand that if information material to the underwriting of this coverage changes, the carrier reserves the right to pursue, without limitation, an adjustment of premiums or coverage, in accordance with such correct facts or information and any other remedies available through operation of law or at equity.

**Important Notice:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Fraud language varies by state, for additional state specific fraud warning language, please see below.)

**Electronic Signature:***Please type your First and Last Name.*

Title: \_\_\_\_\_

Date: \_\_\_\_\_

☐ I understand that checking this box constitutes a legal signature confirming that I understand and agree to the above Terms of Acknowledgement. **Please do not forget to type your name in the E-Signature section.**

Please email completed form to [SpecialRiskSolutions@BerkleyAH.com](mailto:SpecialRiskSolutions@BerkleyAH.com)

## IMPORTANT NOTICE

**For residents of California:** For your protection California law requires the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

A false statement in an application shall not bar the right to recovery under the Policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company.

**For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**For residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**For residents of Kansas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

**For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**For residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For residents of Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**For residents of New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**For residents of Ohio and Oklahoma:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**For residents of Oregon:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For residents of Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

This proposal is for an Accident Only Policy.

The insurance described in this document provides limited benefits. Limited benefit plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential coverage as set forth under the Patient Protection and Affordable Care Act.