Berkley Accident and Health
a Berkley Company

Business Travel 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:
Website Address:		Nature of Business:	
SIC Code:	Total Employees:	Total Employees to be Covered under this BTA policy:	

Business Type: ☐ Corporation ☐ Association ☐ Partnership ☐ Other

Subsidiaries Included? ☐ No ☐ Yes

Do you have more than 250 employees in one or more locations? ☐ No ☐ Yes (If yes, provide city, state and zip code)

_____

Domestic Travel Assessment for U.S. Payroll

(Domestic / U.S.-based trips taken by U.S. employees)

Please attach detailed census or complete the below.

	Class 1	Class 2	Class 3	Class 4
Class Description *(Please describe)*				
Number of Employees				
1 to 10 Travel Days/Year *(List number of employees traveling for this duration)*				
11 to 25 Travel Days/Year				
26 to 49 Travel Days/Year				
50 Travel Days or More				
Covered Hazard(s) *(Business Travel only, Business & Pleasure, etc.)*				
Average Salary				
Highest Salary in Class				
Maximum Principal Sum				
Number of Company Cars				
Number of Truck Drivers				
Long-Haul, Regional, Local				

If salary is used to determine the Principal Sum, how is "Salary" defined? _____

Please attach a list of employees per Class with their annual salary, if required to calculate benefit amount.

International Travel Assessment for U.S. Payroll

(International trips taken by U.S. employees)

Please attach detailed census or complete the below.

	Class 1	Class 2	Class 3	Class 4
Class Description *(Please describe)*				
Number of Employees				
1 to 10 Travel Days/Year *(List number of employees traveling for this duration)*				
11 to 25 Travel Days/Year				
26 to 49 Travel Days/Year				
50 Travel Days or More				
Covered Hazard(s) *(Business Travel only, Business & Pleasure, etc.)*				
Average Salary				
Highest Salary in Class				
Maximum Principal Sum				
Number of Company Cars				
Number of Truck Drivers				
Long-Haul, Regional, Local				

If salary is used to determine the Principal Sum, how is "Salary" defined? _____

Please attach a list of employees per Class with their annual salary, if required to calculate benefit amount.

Foreign Exposures

(Trips taken by employees based in a foreign country)

Destination	Average Number of Trips	Average Number of Travelers	Average Length of Stay

Supplemental Out-of-Country Benefits Plan Design

	Limit	Deductible per Person per Accident/Sickness	Benefit Period
☐ Accident & Sickness Medical ☐ Accident & Emergency Sickness			

War Risk

Is War Risk Coverage desired? ☐ No ☐ Yes (Please attach detailed information or complete the below)

Visited Country	Length of Stay	Average Number of Trips

Over Age 70 Information

A reduction schedule will apply to all insureds over the age of 69 unless otherwise specified. This Schedule reduces benefits applicable to employees over the age of 69. Please attach a list of individuals over age 69 (including Class and date of birth) only if no reduction in benefits is to be applied to those employees over age 69.

Would you like an age reduction schedule applied? ☐ No ☐ Yes (Please attach list of employees)

Requested Benefits *(Check all that apply)*

☐ Accidental Death Only ☐ Accidental Death and Dismemberment ☐ Coma ☐ Paralysis

Aggregate Limit of Indemnity $_____ ☐ Per Accident ☐ Other _____

Please specify the benefit limit for the following:

☐ Home Alteration and Vehicle Modification $_____ ☐ Rehabilitation $_____ ☐ Seat Belt and Airbag $_____

☐ Bereavement and Trauma Counseling $_____ ☐ Repatriation of Remains $_____ ☐ Felonious Assault $_____

☐ Emergency Medical Evacuation $_____ ☐ Security Evacuation $_____ ☐ Political Evacuation $_____

Additional Benefits (specify) _____

_____

Additional Services *(Check all that apply)*

☐ Security Assistance Services ☐ TRIP Portal Access

Company Aircraft Information

Does the company (or any subsidiary/division) own, lease, or operate any aircraft? ☐ No ☐ Yes
If Yes, please complete the chart below. If more than three aircraft, please attach detailed information.

Year	Make	Model	Serial Number	Seating		Average Occupancy	Average Usage
				Passenger	Crew		

Will pilots be covered? ☐ No ☐ Yes If yes, is piloting coverage for company aircraft only? ☐ No ☐ Yes

Important Note: A completed Pilot History form is required for each pilot to be covered.

Unusual or Hazardous Exposures

Are there any known concentrations, unusual or hazardous exposures to be covered?	☐ No ☐ Yes
Are there any employees whose job duties take place in moving vehicles? Examples include but are not limited to tug boats, ferries, other water carriers, and trucks.	☐ No ☐ Yes
Are there any employees whose occupational duties regularly take place off-site? Examples include but are not limited to field electric work, construction, and excavation.	☐ No ☐ Yes

If you have responded Yes to any of these questions, please describe: _____

_____

_____

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? If no, please describe the benefit/plan changes from year-to-year in detail: _____ ☐ Yes ☐ No

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	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 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 an 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 will 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

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.