

APPLICATION FOR ACCIDENT INSURANCE POLICY
 This is a Limited Benefit Policy

Please print all answers:

1. Owner (Applicant) – Owner is the Primary Insured:			
(a) Owner Name (First/MI/Last):			
(b) Date of Birth (Mo./Day/Yr.):	(c) Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		(d) Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
(e) Home Address (Street, City, State, Zip Code):			
(f) Home Phone Number:	(g) E-mail Address: (optional)		(h) Social Security Number:
(i) Occupation:		(j) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time (Number of hours per week _____)	
(m) Coverage Type: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Family (Includes employee, spouse, and child(ren))			

2. Dependents (Indicate the names of all dependents to be insured under the policy.)					
Name (First/Last)	Date of Birth	Sex	Name (First/Last)	Date of Birth	Sex
Spouse:			Child:		
Child:			Child:		
Child:			Child:		

3. Benefit Selection	
Accident Benefit Plan: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> 24-Hour Coverage <input type="checkbox"/> Off Job Accident Coverage Only	Optional Riders: <input type="checkbox"/> Return of Premium Benefit Rider <input type="checkbox"/> Monthly Income Benefit Rider: <input type="checkbox"/> 6 Months <input type="checkbox"/> 12 Months

4. Premium
Accident Policy: \$ _____
Monthly Income Benefit Rider: \$ _____
Return of Premium Benefit Rider: \$ _____

5. Premium Payment		
Premium Payment Mode <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	Billing Method (Select One): <input type="checkbox"/> Payroll Deduction <input type="checkbox"/> ACH/EFT (Checking Account-enclose voided check)	Name of Financial Institution:
		Account Number:

6. Beneficiary				
Name (First, MI, Last)	Date of Birth	Relationship	Percentage	Beneficiary Type
				Primary
				Contingent

You must sign and date the reverse

7. Representations – Owner Agreement

I agree that: (1) the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief; (2) this application will be part of the policy for which I apply; (3) I understand that this policy will be renewed on each policy anniversary date for a new 12-month period, unless I give written notification to Professional Insurance Company to terminate the policy 60 days prior to the policy renewal date, and (4) I will notify Professional Insurance Company if any statements or answers given in this application change prior to policy delivery, I have received the Outline of Coverage.

I hereby authorize Professional Insurance Company to withdraw premium payments from the financial institution and account named above under Section 5 of this application. I understand that this authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdrawal by notifying the financial institution at least three business days before the withdrawal is made. In the event of a withdrawal error, I must promptly notify the financial institution to preserve any rights I may have. I understand that I may direct my billing inquiries to Professional Insurance Company.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; and (c) waive any information the Insurer requests. 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.

The policy provides accident benefits only. Review your policy carefully.

Signature of Owner (Primary Insured)

Date Signed

State in which Policy will be Delivered

State in which Owner Signed Application

Printed Name of Licensed Insurance Agent

Signature of Licensed Insurance Agent

Agent License Number