

# Enrollment for Accident & Accidental Death Insurance

## Enrollment Form for Accidental Death and Accident Medical Benefits

### Part I Proposed Policyholder *Please print or type*

a. Full Legal Name of Proposed Policyholder \_\_\_\_\_

b. Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

c. Specified Activity \_\_\_\_\_

d. Requested Effective Date \_\_\_\_\_

Termination Date \_\_\_\_\_

*Policy will become effective on the Requested Effective Date if (a) all required information is provided and (b) the Company has received the initial premium on or before that date.*

### Part II Plan of Insurance and Premium Calculation

a. Plan of Benefits

Accidental Death & Dismemberment Principle Sum \$ \_\_\_\_\_

Maximum Medical Expense Benefit \$ \_\_\_\_\_

Deductible Amount \$ \_\_\_\_\_

Scope of Coverage

Primary  Full Excess

Policy to Cover

All Enrollees and Staff of the Policyholder  All Enrollees of the Policyholder

b. Premium Calculation

(1) Number of Enrollees \_\_\_\_\_ + Number of Staff \_\_\_\_\_ = Total Eligibles \_\_\_\_\_

(2) Total Eligibles \_\_\_\_\_ x Rate of \$ \_\_\_\_\_ = \$ \_\_\_\_\_

*Minimum Premium is \$300.00*

### Part III Acknowledgements and Signatures

a. **Fraud Warning** 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 may be a crime.

b. **Applicant's Acknowledgement** I, the applicant, declare, to the best of my knowledge and belief, that all statements and answers in this application are true and complete. I understand and agree that (a) this application will form part of any policy issued, (b) no information given to or acquired by any representative of the Company will bind it, unless it is in writing on this application, (c) no waiver or modification will bind the Company unless it is in writing and is signed by an executive officer of the Company, and (d) only those persons eligible under the terms of an issued policy will be insured.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed by Licensed Agent

\_\_\_\_\_  
Agent Phone Number

\_\_\_\_\_  
Signed for the Proposed Policyholder

\_\_\_\_\_  
Licensed Agent Number

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agent Address

Francis L. Dean & Associates of Colorado, LLC



**Francis L. Dean & Associates of Colorado, LLC**

Arapahoe Financial Plaza

6767 South Spruce Street, Suite 280 • Centennial, CO 80112  
(800) 986-5350 • FAX (303) 773-0111 • www.fdeanco.com



Underwritten by Starnet Insurance Company, Acadia Insurance Company or Great Divide Insurance Company, Berkley Group Companies.  
Rated "A+" by A.M. Best Company