Enrollment for JROTC Group Accident 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 $ ____________________

Policy to Cover

☐ **All Participants of the Policyholder** ☐ **All Participants and Staff of the Policyholder**

Scope of Coverage is Full Excess

b. Premium Calculation

(a) Check one: ☐ Short-Term ☐ Annual

(b) Number of Participants __________ + Number of Staff __________ = Total Eligibles __________

(c) Total Eligibles __________ x Number of Days __________ x Daily Rate of $ __________ = $__________

(or) Total Eligibles __________ x Annual Rate of $ __________ = $__________

Minimum Premium is $200.00

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	

Underwritten by Starnet Insurance Company, Acadia Insurance Company or Great Divide Insurance Company, Berkley Group Companies.

Rated "A+" by A.M. Best Company

Francis L. Dean & Associates of Colorado, LLC

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