

Participant Accident Insurance

Enrollment Request Form

CAMPUS

A. Name of Policyholder _____

B. Address _____

C. Requested Start Date of Coverage _____

D. Requested End Date of Coverage _____

E. Policy to Cover Participants only
(please check one box) or Participants and Coaches, Trainers, Team Managers

Accidental Death, Dismemberment Dental, and Paralysis Maximum (offered on all plans)	Accident Medical Expense Maximum	Deductible Amount	Benefit Plan Selection:
\$15,000 Accidental Death Benefit	(MUST SELECT AN AMOUNT) <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$10,000	(MUST SELECT AN AMOUNT) <input type="checkbox"/> \$500 <input type="checkbox"/> \$50	<input type="checkbox"/> Full Excess (not available in NH, OR, PA, or TX)
\$50,000 Accidental Dismemberment (\$15,000 in CT, MN, NH, NJ, PA, SC, TN, TX)	<input type="checkbox"/> \$100,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$250 <input type="checkbox"/> \$25	<input type="checkbox"/> Primary/Excess
\$50,000 Total Paralysis (Not Available: CT, MN, NH, NJ, PA, SC, TN, TX)	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$100 <input type="checkbox"/> \$0	(MUST SELECT A PRIMARY/EXCESS \$ AMOUNT) <input type="checkbox"/> \$100 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500
\$500 Dental	<input type="checkbox"/> \$25,000		<input type="checkbox"/> Primary

G. Policy Premium Computation

Type of Camp			Age Range of Participants	Number of Participants	Standard Plan Rate	Number of Weeks	Total Base Premium
Day (D) or Overnight (O)	Sports (S) or Non-Sport (NS)	Type of Sport or Activity					
						X	=
						X	=
						X	=
Total							

PREMIUM MODIFICATION FACTORS
 (multiply premium modification factors; if applicable against the Total Base Premium)

Total Base Premium	Medical Maximum Factor	Primary Excess Factor	Deductible Factor	Grand Total Premium
X		X	X	=

\$200 Minimum

H. I understand and agree that this is only an enrollment request form and is not an agreement to bind coverage. If quote is agreed upon by both the Agent/Broker and the Insurance Company and payment of the required premium is remitted, coverage will begin on the date premium is remitted or on the date indicated in Section C, whichever is later.

Signature of Applicant _____ Date Signed _____

Signature of Agent/Broker _____ Date Signed _____

Agent/Broker Name, Address _____

Phone _____

Remit with Premium to: MIC Insurance Brokerage, 552 S. Washington Street Suite 200 Naperville IL 60540