



CAMP ACCIDENT MEDICAL APPLICATION

P.O. Box 2009, Glen Allen, VA 23058-2009
(800) 431-1270 Fax (804) 527-7966

Camp Name: _____

Camp Administrator's Name: _____

Summer Mailing Address: _____

City: _____ State: _____ Zip: _____

Summer Phone: (____) _____ Winter Phone: (____) _____

Winter Mailing Address: _____

City: _____ State: _____ Zip: _____

Desired Policy Effective Date: ____/____/____

1. Is the camp ACA accredited? [] Yes [] No Is the camp a member of CCCA? [] Yes [] No

2. Name of sponsoring organization (if any): _____

3. Type of Camp: [] Organizational [] Church [] Private

[] Resident [] Day [] Weekend

4. Camp Open: [] Five days [] Six days [] Seven days [] Other:

5. Is this a sports camp? [] Yes [] No If yes, what sport? _____

6. Is this a specialty camp? (e.g. computer, disability serving) [] Yes [] No If yes, specify? _____

7. Number of camp doctors on premises: _____

8. Number of camp nurses on premises: _____

9. Previous Insurance: If a Camper insurance program has been carried in the past, please give the following details for the past 3 years. (Note: This section is not required if coverage was previously carried with Markel Insurance Company.)

No prior coverage: []

Policy Year: _____

Premium: \$ _____ \$ _____ \$ _____

Losses: \$ _____ \$ _____ \$ _____

10. Is staff to be covered? [] Yes [] No If yes, estimated number of staff per week: _____

11. Are volunteers to be covered? [] Yes [] No If yes, estimated number of volunteers per week: _____

12. What is the pre-camp arrival date for staff: ____/____/____ Departure Date: ____/____/____

13. What is the camp opening date? _____/_____/_____ Camp Closing Date: _____/_____/_____
14. What is the estimated number of campers per week? _____
15. What is the age range of campers? _____(youngest) through _____ (oldest)
16. Check Desired Plan:

Plan-Primary Check desired plan	Accident Medical Expense	Accidental Death and Dismemberment	Primary Sickness Medical Expense	Catastrophe Cash	Aggregate
Resident Camps					
<input type="checkbox"/>	\$3,500	\$5,000	\$1,000	\$25,000	\$250,000
<input type="checkbox"/>	\$3,500	\$10,000	\$1,000	\$25,000	\$250,000
<input type="checkbox"/>	\$5,000	\$10,000	\$1,000	\$25,000	\$250,000
<input type="checkbox"/>	\$12,500	\$15,000	\$1,000	\$25,000	\$250,000
Day Camps					
<input type="checkbox"/>	\$3,500	\$5,000	\$0	\$25,000	\$250,000
<input type="checkbox"/>	\$3,500	\$10,000	\$0	\$25,000	\$250,000
<input type="checkbox"/>	\$5,000	\$10,000	\$0	\$25,000	\$250,000
<input type="checkbox"/>	\$12,500	\$15,000	\$0	\$25,000	\$250,000

NOTES: Catastrophe Cash not available in New York. Sickness Medical Expense not available in Washington and New Jersey.

Special Conditions

1. \$350 minimum premium per policy on Mandatory Benefits
2. There is a \$0 deductible for all plans.
3. The Insurance Company reserves the right to audit camp records.
4. All pre-existing health conditions are excluded.

Coverage shall not be bound until the Company approves the applicant's completed application and premium payment is received. The Company's receipt of premium does not bind coverage until the completed application is also approved. In the event the Company does not approve your application, your premium payment will be refunded.

Fair Credit Report Act Notice: Personal information about you, including information from a credit or other investigative report, may be collected from persons other than you in connection with this application for insurance and subsequent amendments and renewals. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization. Credit scoring information may be used to help determine either your eligibility for insurance or the premium you will be charged. We may use a third party in connection with the development of your score. You have the right to review your personal information in our files and can request correction of any inaccuracies. A more detailed description of your rights and our practices regarding such information is available upon request. Contact your agent or broker for instructions on how to submit a request to us.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and (NY substantial) civil penalties. (NOT APPLICABLE IN: CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA) (INSURANCE BENEFITS MAY ALSO BE DENIED IN LA, ME, TN, and VA.) For additional warnings, please visit:
<http://www.markelinsurance.com/Applications/Pages/FraudWarnings.aspx>

I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which would materially affect this insurance has been withheld.

Applicant's Signature: _____ Date: _____

Producer Signature: _____ Date: _____

Agency Name: _____

Agency Address: _____ City/State/Zip _____