



BUSINESS TRAVEL ACCIDENT APPLICATION

1. Name : _____
2. Address: _____
3. Email: _____ Website Address: _____
4. Nature of Business: _____ Standard Industrial Classification (SIC): _____

TRAVEL SURVEY

	Class 1	Class 2	Class 3	Class 4
Principal Sum Desired				
Coverage Desired (Business & Pleasure, Business Travel only, Other)				
Total # of Employees				
Over 50 Travel Days/Year*				
25 to 50 Travel Days/Year*				
10 to 25 Travel Days/Year*				
1 to 9 Travel Days/Year*				
0 Travel Days/Year*				
Number of Company Cars				
Number of: Truck Drivers, Chauffeurs, &/or Deliverymen				
Highest Salary				
Lowest Salary				
Average Salary				

* DEFINITION OF A TRAVEL DAY: A day of travel on business is a day or any part thereof that a person is away from his or her regular place of employment on company business. (This includes meetings across town, post office runs as well as bona fide "business trips")

5. Please select from one or more of the following Class Descriptions by writing in the appropriate Class Number (i.e. 1, 2, etc) next to the corresponding Class Description or create your own description in the space(s) provided. **

- | | |
|--------------------------------------|-------------------------------|
| _____ All Active Full-Time Employees | _____ All Executive Officers |
| _____ All Other Employees | _____ All Part-Time Employees |
| _____ All Senior Management | _____ All Salaried Employees |
| _____ All Consultants | _____ All Owners |
| _____ All Partners | _____ All Hourly Employees |
| _____ All Sales Employees | _____ All Principals |
| _____ _____ | _____ _____ |
| _____ _____ | _____ _____ |

6. For flat Principal Sums of \$1,000,000 or greater, a salary survey for all insured persons in the respective class is requested. Attach a separate spreadsheet if necessary.

Class #	Name	Salary





** Please note that you will only need multiple Classes if providing different coverage amounts and limits for different employees. For instance if the intent was to cover all employees for business only coverage at a benefit amount of \$100,000, only 1 class would be necessary and might read as "All active full-time employees of the Policyholder." If however you wanted to provide all executive officers with \$500,000 of business & Pleasure coverage and all other employees with \$100,000 of business only coverage the policy might read as follows:

Class 1: All Executive Officers of the Policyholder \$500,000 Business & Pleasure
 Class 2: All Other Active Full-Time Employees of the Policyholder \$100,000 Business Travel Only

OVER AGE 70 INFORMATION

7. Are any Insured Persons over age 70: Yes No
 If yes, please provide a list of names, dates of birth, salary, and applicable Class.

Name	Date of Birth	Salary	Class #

FOREIGN EMPLOYEES

8. Are there any employees that are employed outside the United States: Yes No
 If yes, please complete the table below:

Country of Employment	# of Employees located in listed country	# of Employees who are citizens of the listed country	# of Employees who are U.S. Citizens	Average Salary

9. Are there any employees that engage in foreign travel: Yes No

FOREIGN TRAVEL

10. Do any employees employed in the United States travel outside of the United States: Yes No
 If yes, please indicate to the best of your ability the total number of employees that travel overseas on business, the countries frequently visited, and the total number of days spent in each country.

Total # of Employees Traveling Overseas	Countries Visited	Total # of Days Spent in each country



ADDITIONAL BENEFITS

11. Please list any Additional Benefits being requested: _____

AGGREGATE LIMIT

12. What is the requested Aggregate Limit: _____ per accident

OWNED/LEASED AIRCRAFT

13. Are there any Owned, Leased or Operated aircraft to be covered: Yes No
 If yes, please fill out the applicable information below:

Type of Aircraft (Fixed Wing, Rotorcraft, etc)	Year	Make	Model	Serial Number	Seating Capacity	Average Occupancy	Hours Flown per year

14. Are pilots and crew to be covered on the policy: Yes No
 If yes, please provide pilot history form(s)

LOCATION DATA

15. Does the policyholder have offices in New York City, Chicago, Boston, Philadelphia, or Washington DC: Yes No

16. If the Policyholder has multiple locations please provide the address and number of Employees for ALL Locations (Include street, city, zip, and number of employees for each location.)***

Street Address: _____	Street Address: _____
City: _____	City: _____
State: _____	State: _____
Zip: _____	Zip: _____
# of Employees: _____	# of Employees: _____

Street Address: _____	Street Address: _____
City: _____	City: _____
State: _____	State: _____
Zip: _____	Zip: _____
# of Employees: _____	# of Employees: _____

*** Please attach additional pages if necessary

PRIOR COVERAGE

17. Is there an accident insurance policy (or business travel policy) currently in force: Yes No
 Effective Date: _____ Expiration Date: _____

18. Have there been any Travel Accident claims or Workers Comp death claims within the past 5 years: Yes No
 If yes, please attach documentation detailing these claims

19. Please attach all available details of current program, including coverage, benefits, limits provided, copies of policies, and five (5) years premium and loss experience.





PRODUCER INFORMATION

- 20. Name: _____
- 21. Street Address: _____
- 22. City: _____ State: _____ Zip Code: _____
- 23. Contact Name: _____ Phone Number: _____
Email Address: _____ Fax Number: _____
- 24. Are you a licensed A&H Producer in the applicable risk state: Yes No
- 25. Are you an appointed A&H Producer with Chubb: Yes No
- 26. Requested Commission (%): _____

COVERAGE DEFINITIONS

Business & Pleasure – Covers an Insured Person 24 hours a day 7 days a week. To be covered the Insured Person DOES NOT have to be on the business of the Policyholder

Business Travel Only Hazard – Covers the employee 24 hours a day while traveling ONLY on the business of the Policyholder. Coverage commences when the Insured person leaves his or her regular place of employment and/or residence, whichever occurs last, on behalf of the Policyholder. Coverage ends upon return to his or her regular place of employment and/or residence, whichever occurs first.

Date: _____ Completed By: _____

Print Name/Title: _____

Signature: _____

