



A Member of the Tokio Marine Group

REQUEST FOR QUOTE – BUSINESS TRAVEL ACCIDENT

Submission Date:

Quote Due Date:

Requested Effective Date:

RISK INFORMATION

Name of Organization:

Street Address:

City:

State:

Zip Code:

1. Do you current have Business Travel Accident coverage? Yes No
If yes, please provide a copy of your policy's schedule page.

TRAVEL ASSESSMENT

1. Please complete the chart below based on your current coverage. If changes are desired, please indicate where applicable. **Attach a separate sheet of paper if additional room is needed.**

	Class 1	Class 2	Class 3	Class 4
Class Description: (i.e. Managers, Sales, All Employees)				
Benefit Amount**				
Type of Coverage (Business Travel Only, Business and Pleasure or Full Occupational)				
Total Number of Insureds:				
Number of Insureds Who Travel on Business:				
Over 50 days per year*				
26 – 50 days per year*				
10 – 25 days per year*				
1 – 9 days per year*				
0 days per year*				
# of Truck Drivers, Chauffeurs, and / or Deliverymen				
Number of Company Cars				
Average Salary of Travelers				

*Any time away from the office (business lunches, client visits, etc.) is considered a day of travel.

**If salary is used to determine the benefit for a Class, please attach a salary census for all the insureds in that Class.

AFFILIATED COMPANIES / SUBSIDIARIES

1. List affiliated companies / subsidiaries to be included under this program and their nature of business. Remember to include the affiliated companies' travel exposure in the travel assessment above.

COMPANY AIRCRAFT

1. Does your company own, operate, or lease any aircraft? If yes, complete the chart below. Yes No

Year	Make & Model	FAA or Serial #	Crew Seats	Passenger Seats	Avg. Occupancy	Avg. Usage

2. Do you wish to cover employee pilots? If yes, please list their names and their respective type of pilot license. Yes No

70 AND OVER EMPLOYEES

1. Are there any employees age 70 or greater that are to receive full benefits? Yes No
 a. If yes, please complete chart below.
 b. If no, our standard benefit reduction will apply. This schedule reduces benefits applicable to employees age 70 or greater.

Date of Birth	Class Number

WAR RISK COVERAGE:

1. Is War Risk* coverage desired? If yes, please complete chart below. Yes No

Visited Country	Length of Stay	Average Number of Trips

*War or act of war is a standard exclusion on Travel Accident policies. In order to have coverage for losses resulting from war or acts of war, war risk coverage must be purchased.

ACKNOWLEDGEMENTS AND SIGNATURES

- a. **Fraud Warning** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
- 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 Philadelphia Indemnity Insurance 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 office of Philadelphia Indemnity Insurance Company and (d) only those persons eligible under the terms of an issued policy will be insured.

Signed: _____ Title: _____ Date: _____

Agent Name: _____ Agency: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Email: _____ Phone: _____ Fax: _____

Are you a licensed A&H Producer in the applicable risk state? Yes No

Please return form to: Philadelphia Insurance Companies, 500 Mamaroneck Avenue, Suite #402, Harrison NY 10528
AH@phly.com • Phone: 1.800.734.9326