REQUEST FOR HIGH LIMIT ACCIDENTAL DEATH AND DISMEMBERMENT AND DISABILITY INSURANCE

Insurance Requested

	Select	$ Amount				
Accidental Death Only (AD)	☐		☐ 24 Hour	☐Travel Accident Only		
Accidental Death & Dismemberment (ADD)	☐		☐ 24 Hour	☐Travel Accident Only		
Permanent Total Disability (PTD)	☐		☐ Accident	☐Accident & Sickness		
Temporary Total Disability (TTD)	☐		Per month	How many months?		
			60 days	90 days	180 days	Other
	☐Accident Only		☐	☐	☐	
	☐Accident & Sickness		☐	☐	☐	

Please answer all questions

NAME IN FULL	First		M.I.		Last	
RESIDENTIAL ADDRESS						
	City		State		Zip Code	
PROFESSION or OCCUPATION (If more than one, state all)						
NATURE OF DUTIES						
DATE OF BIRTH		HEIGHT		WEIGHT		☐MALE ☐FEMALE
PERIOD OF INSURANCE	12 months	36 month	Other			
	☐	☐				

1. a) Are you now and have you been perfectly well and in sound health for a year preceding this request?	
☐Yes ☐No	
b) Have you consulted a doctor during the past two years?	
☐Yes ☐No	If YES, please give dates, and for what reasons
c) Have you any physical defect or infirmity?	
☐Yes ☐No	If YES, please explain
d) Is your sight in any way impaired? Have you ever suffered from any disease of the eyes?	
☐Yes ☐No	If YES, please explain.
e) Is your hearing impaired? Have you ever had any discharge from the ears?	
☐Yes ☐No	If YES, please explain.
f) Have you, to your knowledge, during the past 21 days been exposed to any infectious or contagious diseases?	
☐Yes ☐No	If YES, please explain.

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2. a) Are you now insured against accident or illness?	
☐Yes ☐No	If YES, with whom, and for what benefits?
Please include current Disability Income policies, if income replacement is subject of this request.	
Insurance Carrier	Benefit
b) Have you made any claims with respect to accident or illness?	
☐Yes ☐No	If YES, in each case please state nature of claim, amount, and the name of insurer.

Nature of claim	Amount	Name of Insurer

3. Have you ever been declined, or accepted on special terms, for Life Insurance or Insurance against Accident or Illness?	
☐Yes ☐No	If YES, please explain.
4. Has any Insurer ever canceled or declined to renew your Policy?	
☐Yes ☐No	If YES, please explain.
5. Are you now applying for any other Insurance against accident or sickness?	
☐Yes ☐No	If YES, with whom and for what benefits?
Insurance Carrier	Benefit
6. Do you intend to travel by air during the term of this proposed Insurance?	
☐Yes ☐No	If YES, please estimate number of:

a) Round Trips by scheduled airlines		d) Flights in private planes	
b) Round Trips by non-scheduled or charter lines		e) Flights in Helicopters	
c) Flights in company owned plane			

7. Answer the following if the insurance for which you are requesting includes an Accidental Death Benefit.

Beneficiary	
Relationship	
Address	

I hereby attest that all the information given by me to the foregoing questions and statements is true to the best of my knowledge.	
SIGNATURE OF APPLICANT (Person to be insured)	Date
Policy-owner is to be:	
☐Person to be insured ☐ Other	If other , please complete the following:
Name	
Address	

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	City		State		Zip Code	

BROKER / AGENCY						
CONTACT PERSON						
ADDRESS						
	City		State		Zip Code	
TELEPHONE NUMBER						
FAX NUMBER						

Please forward complete form and attach any other information to:
Star Line Group Attn: Accident & Health Underwriting Dept. E-mail: quotes@starlinegroup.com Or Fax to: 508.495.0708 Phone: 508.495.0882

Name/signature of person completing questionnaire	Date