



**REQUEST FOR HIGH LIMIT ACCIDENTAL DEATH AND DISMEMBERMENT
AND DISABILITY INSURANCE**

Insurance Requested

	Select	\$ Amount				
Accidental Death Only (AD)	<input type="checkbox"/>		<input type="checkbox"/> 24 Hour <input type="checkbox"/> Travel Accident Only			
Accidental Death & Dismemberment (ADD)	<input type="checkbox"/>		<input type="checkbox"/> 24 Hour <input type="checkbox"/> Travel Accident Only			
Permanent Total Disability (PTD)	<input type="checkbox"/>		<input type="checkbox"/> Accident <input type="checkbox"/> Accident & Sickness			
Temporary Total Disability (TTD)	<input type="checkbox"/>		Per month		How many months?	
			60 days	90 days	180 days	Other
			<input type="checkbox"/> Accident Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Accident & Sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
PERIOD OF INSURANCE	12 months	36 month	Other		
	<input type="checkbox"/>	<input type="checkbox"/>			

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



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<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please explain.		
2. a) Are you now insured against accident or illness?			
<input type="checkbox"/> Yes <input type="checkbox"/> 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?			
<input type="checkbox"/> Yes <input type="checkbox"/> 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?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please explain.		
4. Has any Insurer ever canceled or declined to renew your Policy?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please explain.		
5. Are you now applying for any other Insurance against accident or sickness?			
<input type="checkbox"/> Yes <input type="checkbox"/> 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?			
<input type="checkbox"/> Yes <input type="checkbox"/> 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:	
<input type="checkbox"/> Person to be insured <input type="checkbox"/> Other	If other , please complete the following:



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Name					
Address					
	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:
<p>StarLine Group Attn: Accident & Health Underwriting Dept. E-mail: quotes@starlinegroup.com Or Fax to: 508.495.0708 Phone: 508.495.0882</p>

Name/signature of person completing questionnaire	Date