



STAR·LINE
GROUP

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT
UNDERWRITING QUESTIONNAIRE**

GENERAL INFORMATION

COMPANY INFORMATION	(Legal Name)		
	(Street Address – No PO Boxes, please!)		
	(City)	(State)	(Zip Code)
OFFICE / PLANT LOCATIONS	(U.S. States)	(Foreign Countries)	
NATURE OF BUSINESS			
SIC CODE(S)			
TOTAL NUMBER OF EMPLOYEES			
U.S. SUBSIDIARY OR AFFILIATE COMPANIES TO BE INCLUDED	(Name)	(State)	(No. of Employees)

PROPOSED EFFECTIVE DATE					
PRESENT VOLUNTARY AD&D COVERAGE (Please provide a copy of the current policy, certificate, or summary plan description)	Name of Insurance Co.:				
	Experience for the last 3 years	Year	Premium	Claims	# of Claims
			\$	\$	
			\$	\$	
			\$	\$	
	Have changes to benefits, limits or coverage occurred during this time frame?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, please explain: ⇨				
Current enrollment information:	Coverage Option	# Enrolled	Covered Volume		
(A census or premium reporting form containing this information is also acceptable)					

BROKER / PRODUCER / CONSULTANT INFORMATION

NAME / TITLE				
FIRM NAME				
ADDRESS	(Street Address)			
	(City)	(State)	(Zip Code)	
PHONE NUMBER		FAX NUMBER		
EMAIL ADDRESS				
COMMISSION	<input type="checkbox"/> Yes, ___ % <input type="checkbox"/> No	CURRENT BROKER / PRODUCER OF RECORD?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Consultant Only	



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PLAN DETAILS

1. DESCRIPTION OF EMPLOYEES TO BE COVERED																		
2. NUMBER OF ELIGIBLE EMPLOYEES																		
3. COVERAGE OPTIONS	<input type="checkbox"/> Employee Only																	
	<input type="checkbox"/> Employee Only plus Employee & Family																	
	<input type="checkbox"/> Employee Only, Employee & Spouse, Employee & Child(ren), plus Employee & Family																	
	<input type="checkbox"/> Other, Please specify: ⇨																	
4. AMOUNT OF INSURANCE <small>(Note: Selections, regardless of whether a flat amount or multiple of salary, are limited to 10x salary)</small>	<input type="checkbox"/> Flat Amount: Increments of \$ _____ Minimum Amount \$ _____ Maximum Amount \$ _____																	
	<input type="checkbox"/> Multiple of salary: ___ x (times) salary to ___ x (times) salary Minimum Amount \$ _____ Maximum Amount \$ _____ Rounding <input type="checkbox"/> Next higher \$1000 <input type="checkbox"/> Other, specify: ⇨																	
5. SALARY INFORMATION	If Amounts of Insurance are based on a Multiple of Salary, please provide: ⇨																	
	Average Salary \$ _____ Highest Salaries* 1. \$ _____ 2. \$ _____ 3. \$ _____ 4. \$ _____ 5. \$ _____ Salary is assumed to exclude bonuses, commission, overtime, and any other special compensation. If a specific definition of salary is desired, please provide: ⇨																	
6. AGE REDUCTION SCHEDULE	<input type="checkbox"/> Amounts of insurance are to reduce based on age.																	
	A standard age reduction schedule will apply to employees age 70 and older. If another schedule is desired, please describe: ⇨																	
	<input type="checkbox"/> Full amounts of insurance are desired for employees age 70 and over.																	
	Please provide number of employees over age 70 by applicable Class: ⇨	<table border="1"> <thead> <tr> <th>Age</th> <th>Class I</th> <th>Class II</th> </tr> </thead> <tbody> <tr> <td>70 to 74</td> <td></td> <td></td> </tr> <tr> <td>75 to 79</td> <td></td> <td></td> </tr> <tr> <td>80 to 84</td> <td></td> <td></td> </tr> <tr> <td>85+</td> <td></td> <td></td> </tr> </tbody> </table>	Age	Class I	Class II	70 to 74			75 to 79			80 to 84			85+			
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PLAN DETAILS (continued):

7. FAMILY PLAN ELIGIBILITY	<input type="checkbox"/> Spouse <input type="checkbox"/> Spouse/Domestic Partner	Children to age ____ or to age ____ if a full-time student				
8. FAMILY PLAN	Amounts of Insurance for the Family Plan are a percentage of the Employee's amount as follows: Spouse Only: ____ % Spouse with Child(ren): ____ % Child(ren) Only: ____ % Child(ren) with Spouse: ____ % Maximum each Child \$ _____					
9. COMPANY-OWNED OR LEASED AIRCRAFT INFORMATION	Do you wish to provide coverage while flying in company-owned or leased aircraft? <input type="checkbox"/> Yes, please provide details below: ↗ <input type="checkbox"/> No					
	Year	Make	Model	Registration #	Seating Capacity	
					Passenger	Crew
	Are the above aircraft owned or leased? If leased, please explain contract and/or arrangement. ↗					
	Are company pilots and crew to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Pilot History Forms must be completed for each pilot and can be found at www.starlinegroup.com/04.pdf					
10. WAR RISK COVERAGE	Is War Risk coverage desired? <input type="checkbox"/> Yes, please provide: ↗ <input type="checkbox"/> No					
	PLEASE PROVIDE THE BEST ESTIMATES REGARDING ANY INTERNATIONAL TRAVEL BY U.S. EMPLOYEES THAT IS EXPECTED WITHIN THE NEXT YEAR					
	Country	# of Trips	Avg. Duration	Country	# of Trips	Avg. Duration
11. OTHER BENEFITS	Standard coverage provides Accidental Death and Dismemberment and several additional benefits. If any specific benefits are desired, please identify: ↗					



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ADDITIONAL INFORMATION

HOW MANY COMPANY-OWNED OR LEASED AUTOS ARE USED ON BUSINESS?		
IS THERE A LIMIT TO THE NUMBER OF EMPLOYEES ALLOWED TO TRAVEL TOGETHER?	<input type="checkbox"/> Yes, <input type="checkbox"/> No	If Yes, what is the max allowed?
DOES YOUR COMPANY EVER CHARTER AIRCRAFT?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ARE THERE ANY KNOWN CONCENTRATIONS OR UNUSUAL / HAZARDOUS EXPOSURES TO BE COVERED?	<input type="checkbox"/> Yes, please describe: ↗ <input type="checkbox"/> No	

Completed by: (Name and Title)	Signature and Date
<input type="checkbox"/> Company <input type="checkbox"/> Broker / Producer / Consultant	

E-mail: quotes@starlinegroup.com