

## *Special Risk Underwriting Form*

**Name of Policyholder:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Coverage Type: (choose one)**

Full Excess       Primary       Primary Excess Over \$ \_\_\_\_\_

**Benefits & Limits: (Insert the limits desired.)**

Accident Medical Expense: \$ \_\_\_\_\_      Accidental Death: \$ \_\_\_\_\_

Accident Dental Expense: \$ \_\_\_\_\_      Accidental Dismem: \$ \_\_\_\_\_

Sickness Medical Expense: \$ \_\_\_N/A\_\_\_      Accidental Paralysis: \$ \_\_\_\_\_

Deductible: \$ \_\_\_\_\_      Benefit Period: \_\_\_\_\_ Year(s)

**Please describe the activities to be covered, the estimated number of participants for each activity and their ages (i.e. 12 & under, 13-15, 16-18 or 19 & over).**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name of Agency:** \_\_\_\_\_

Address of Agency: \_\_\_\_\_

Agency Tel & Fax: \_\_\_\_\_

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