PSBA INSURANCE TRUST

Request for Volunteers Accident Medical Insurance for Member Schools of Pennsylvania School Boards Association

Instructions to obtain enrollment:
1. Complete this enrollment request form and make sure the form is signed by an authorized representative of your school.
2. Please send this completed form to: Email: bindorder@agadm.com or Fax: 610-933-4122

Submission of this form does not guarantee coverage. Enrollment will be offered if risk meets Underwriting Guidelines. Payment of premium is Named Insured's formal request to obtain insurance through the Volunteers Accident Insurance Program.

Account Information:

Named of School _____
(as to be shown on policy declarations page)

Mailing Address _____ Email _____

City _____ State _____ Zip _____

Fax _____ Website _____

Physical Address _____

Contact Person _____ Title _____ Phone _____

Effective Date _____ Expiration Date _____

Please select one box indicating the desired Plan and select one box indicating the Student Enrollment.

	☐ Plan 1	☐ Plan 2
Accident Medical Maximum Benefit	$ 5,000	$25,000
Accidental Death Benefit	$10,000	$20,000
Single Dismemberment	$ 5,000	$10,000
Double Dismemberment	$10,000	$20,000
Deductible	$0	$100.00

Student Enrollment	☐ Plan 1	☐ Plan 2
❑ 1 – 2,999	$500.00*	$650.00*
❑ 3,000 – 5,999	$950.00*	$1,250.00*
❑ 6,000 – 9,999	$1,400.00*	$1,850.00*
❑ 10,000 & Over	Individually rated and must be submitted for further review and the below question answered.	

Student Enrollment = **Total Due****

_____ = _____

(*Includes a $50.00 PSBA marketing fee that is in addition to the plan rate.)
(**Minimum Premium of $500.00 is due at Policy issuance and is considered fully earned.)

Student Enrollment of 10,000 and over – Has your school had prior accident medical coverage in the past 3 years? ❑ Yes ❑ No
If yes, and there were losses, please list amount of loss paid and the year it was paid: _____

_____

This is subject to carrier approval and may require additional underwriting.

Applicant's Statement and Declarations

The applicant declares to the best of his / her knowledge the information contained in this request for quote form and all supplements attached to be true and that no material facts have been suppressed or misstated. The applicant further understands that any false or fraudulent statements or misrepresentations could result in termination or voidance of any insurance contract issued from the information stated herein.

Authorized Signature_____ **Date**_____

Printed Name _____ **Title**_____

All above information requested is required for policy issuance. The licensed agent is required to complete the section below. Policies can not be issued without all the required information being completed.

Local/Regional Licensed Agency

Agency Name: _____ License Number: _____

Agent Name (Printed): _____ Agent Address: _____

City, State, Zip: _____ Phone Number: _____

Signature: _____ Date: _____
(Licensed Agent)
Email Address: _____ Proposal Number: _____

RETURN COMPLETED FORM TO A-G ADMINISTRATORS, LLC

A-G Administrators, LLC
PO Box 979
Valley Forge, PA
Phone: (800) 634-8628 Fax: (610) 933-4122
bindorder@agadm.com

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: 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.