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VOLUNTEER ACCIDENT INSURANCE APPLICATION

GENERAL INFORMATION

Name of Organization: _____

Organization's Mailing Address: _____
Street or PO Box

City State Zip Code Phone

Approximate Number of Volunteers*: _____ (At rate of \$3.55 / volunteer)

* This number should **NOT** include volunteer firefighters or volunteer ambulance workers.

Proposed Benefits	Class I
Accidental Death and Dismemberment	\$1,000
Accident Medical Expense	\$5,000
Dental Expense	\$250
Deductible	\$0

Aggregate Limit: \$100,000 per covered Accident

COMPLETE IF COVERAGE IS TO BE BOUND

I hereby make application for the above referenced coverage.

Annual Premiums: \$ 0.00 _____

Requested dates of coverage: Effective: _____ Expiration: _____

Name of Contact: _____ Contact Signature: _____