



## Business Travel Accident Insurance Questionnaire

### 1. Employer Information

Name:			
Street Address:			
City:	State:	Zip:	
Nature of Business:		Standard Industrial Classification (SIC):	
Total # of Employees:		Total # of Employees to Be Covered:	

2. Please indicate (below) the Class Description, Principal Sum, Type of Coverage, and The Total Number of Employees Who Travel on Business for each classification. Also, please indicate the Number of Truck Drivers and Helpers, and indicate Long-or Short-Haul Trucking. Mark "N/A" if the information does not apply. Attach another sheet, if necessary.

Please Note: A travel day is any day or part of a day that the Insured Person is away from his or her regular place of business on the business of the policyholder; for example, trip to bank, lunch with client, sales call, etc.

	Class 1	Class 2	Class 3	Class 4
<b>Class Description</b>				
<b>Principal Sum</b>				
<b>Type Of Coverage</b>	<input type="checkbox"/> Business Only <input type="checkbox"/> Business & Pleasure	<input type="checkbox"/> Business Only <input type="checkbox"/> Business & Pleasure	<input type="checkbox"/> Business Only <input type="checkbox"/> Business & Pleasure	<input type="checkbox"/> Business Only <input type="checkbox"/> Business & Pleasure
<b>Travel Days Per Year</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-25 <input type="checkbox"/> 26-50 <input type="checkbox"/> More than 50	<input type="checkbox"/> 0 <input type="checkbox"/> 1-10 <input checked="" type="checkbox"/> 11-25 <input type="checkbox"/> 26-50 <input type="checkbox"/> More than 50	<input type="checkbox"/> 0 <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-25 <input type="checkbox"/> 26-50 <input type="checkbox"/> More than 50	<input type="checkbox"/> 0 <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-25 <input type="checkbox"/> 26-50 <input type="checkbox"/> More than 50
<b>Number of Company Cars</b>				
<b>Number of Truck Drivers and Helpers</b>				

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### 3. Salary

Is salary used to determine the principal sum?  Yes\*  No

*\*If you answered Yes, define "salary" and complete the chart below.*

**Indicate Highest Salary and Average Salary for each Class.**  
**(For Principal Sum amounts over \$50,000, please attach a separate listing of salaries by Class.)**

Class	Average Salary	Highest Salary

Please Note: The Standard Age Reduction Schedule will apply. This reduces benefits applicable to employees over age 69. Please attach a list of individuals over age 69 (including Class and date of birth) *only if* Full Benefits for those employees over age 69 are to be maintained.

### 4. Foreign Employees

Are foreign employees to be covered?  Yes\*\*  No \*\*If Yes, list Name of Country, Number of Employees and Class.

Name of Country	Number of Employees	Class

### 5. Benefits

Accidental Death Only  Accidental Death & Dismemberment

Additional Benefits (Describe):

### 6. Aggregate Limit

What Aggregate Limit of Indemnity is required?

\$ \_\_\_\_\_ /Per  Accident  Aircraft Accident (Please choose one & insert dollar amount.)

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## 7. Company Aircraft Information

Does the company (or any subsidiary/division) own, lease, or operate any aircraft?  Yes  No  
If Yes, complete the chart below.

Year	Make	Model	Serial Number	Seating Capacity		Average Usage
				Passenger	Crew	

Please note any other appropriate details about the aircraft:

Is piloting coverage to be provided?  Yes  No  
If Yes, is piloting coverage for company aircraft only?  Yes  No

Please Note: Pilot history forms must be completed if pilots are covered.

## 8. Unusual or Hazardous Exposures

Are there any known concentrations, unusual or hazardous exposures to be covered?  Yes  No

Are there any employees whose job duties take place in moving vehicles? (Examples include but are not limited to tug boats, ferries, other water carriers, and trucks.)  Yes  No

Are there any employees whose occupational duties regularly take place off-site? (Examples include but are not limited to field electric work, construction, and excavation.)  Yes  No

If you have responded Yes to any of these questions, please describe:

## 9. Prior Coverage

Insurance Company Name: \_\_\_\_\_  
Effective Date: \_\_\_\_\_ Renewal Date: \_\_\_\_\_

**Please attach all available details of current program, including coverage, benefits, limits provided, Summary Plan Description, copies of policies, and a minimum of three (3) years' premium and loss experience.**

# NorthWind, LLC

## 10. Please tell us about your organization.

Producer Name:			
Contact Person:			
Street Address:			
City:	State:	Zip:	
Telephone #:	Fax #:		
E-Mail:	Web:		
Requested Commission:			

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Please forward completed form and attach any available details of current program including coverage, benefits, limits provided, Summary Plan Description, copies of policies, and a minimum of three (3) years premium and loss experience to:

NorthWind, LLC  
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630.922.7954 fax  
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