GUARANTEE TRUST LIFE INSURANCE COMPANY, Glenview, Illinois

Enrollment for Accident Insurance

Please print or type - Complete both sides

Name of Policyholder _____

Policy Number (company use only) _____

Mailing Address _____

Policy Term: Effective Date: _____ Termination Date: _____

Covered Activities: Supervised activities at the Policyholder's facility as well as day trips sponsored and supervised by the Policyholder. Travel directly to and from day trips in a Designated Vehicle provided by the Policyholder.

DEDUCTIBLE PER INJURY - $0	Maximum Benefit Amounts (select ONLY one option)	
	OPTIONS	
BENEFITS	STANDARD ❑	DELUXE ❑
Accidental Death	$5,000	$7,500
Accidental Dismemberment, *Up To*	$10,000	$15,000
Accident Medical Expense	$25,000	$25,000
	Premium Rates Per Eligible Person	
CHILD CARE PROGRAMS	**STANDARD**	**DELUXE**
Summer Only	$1.50	$1.70
9 month, half day	$2.45	$2.70
9 month, full day	$4.15	$4.40
12 month, half day	$3.15	$3.45
12 month, full day	$5.55	$6.55
Montessori / Religious 12 month	$5.55	$7.95
NO REFUNDS ARE AVAILABLE		

Policy to Cover all Eligible Persons, including: ❑ **Participants Only** ❑ **Participants and Staff**

The Policy will become effective on the date requested if the appropriate premium has been received prior to the requested effective date. It is agreed that the premium will be paid entirely by the Policyholder with no contribution made by the eligible persons toward the cost of the insurance.

Authorized Signature _____ Date _____

Printed Name _____ Title _____

Agent Signature _____

Printed Name _____

PREMIUM REPORT

Must be completed for enrollment to be processed
Complete both sides

Dates of Programs	Numbers of Eligible Persons Anticipated to be Insured: Participants	+ Staff	= Total		Premium Rate	= Premium Due
_____ Thru _____	_____	+ _____	= _____	X	$_____	= $_____
_____ Thru _____	_____	+ _____	= _____	X	$_____	= $_____
_____ Thru _____	_____	+ _____	= _____	X	$_____	= $_____

Group Activities: _____

_____

TOTAL PREMIUM: $_____

NOTE: Minimum Premium is $100.00

I certify to the best of my knowledge and belief: 1) the information above is true and correct; 2) the premium is being paid for the total number of eligible persons who are anticipated to be insured during the Policy Term; and 3) the premium is being paid entirely by the Policyholder with no contribution made by the eligible person toward the cost of the insurance.

Authorized Signature: _____ Date: _____

Phone Number: _____ Title: _____

ELIGIBLE PROGRAMS

Day Care Centers, Head Start Programs, Pre-Schools, Nursery Schools, Before/After School Care, Montessori, Religious and Waldorf Day Schools

(Home day care centers ARE NOT eligible for coverage)