



Good Neighbor Insurance

**AFTER FILLING OUT THIS APPLICATION
PLEASE MAIL, FAX, OR EMAIL SCAN TO:**

**Good Neighbor Insurance
690 E. Warner Rd. Suite 117
Gilbert, AZ 85296, USA**

Toll Free: 866-636-9100 • Phone: 480-633-9500 • Fax: 480-813-9930

info@gninsurance.com

www.gninsurance.com

To Get Up-To-Date Insurance Information



**Good Neighbor Travel Blog
www.gntravelinsurance.com**



**Tips For Understanding
International Insurance**



**Follow Us On Twitter at:
<http://twitter.com/GoodNeighborIns>**



HIGH LIMIT ACCIDENT APPLICATION

Proposed Insured: First _____ Middle _____ Last _____

Personal Statistics: Date of Birth ____/____/____ Height _____ Weight _____ Gender Male Female

Contact Information: Email _____ Telephone (____) _____ - _____ Fax (____) _____ - _____

Residence Address: Number & Street _____

City _____ State _____ Zip Code _____

Employer: _____

Business Address: Number & Street _____

City _____ State _____ Zip Code _____

Countries to be visiting outside the U.S. (if any): _____

Air Travel: Will aviation travel be on regularly scheduled airlines? If no, please provide details: Yes No: _____

Occupation: _____ Annual Income US\$ _____

Period of Insurance: Effective Date _____ Expiry Date _____

Sum Insured: US\$ _____ (Not to exceed 10 times annual income or satisfactory justification must be submitted)

Policy Owner (If not the insured): _____ Relationship _____

Address: _____

Beneficiary: _____ Relationship _____

Address: _____

Benefits (Check one): 24 Hour or Common Carrier or Air Travel Only

Options: Acts of War & Terrorism

Coverage (Check one): Accidental Death (AD) or Accidental Death & Dismemberment (AD&D) or Accidental Death, Dismemberment & Accidental Permanent Total Disability (AD&D & APTD)

Please answer all the questions and provide dates and details in the area below

- | | | | |
|---|--|--|--|
| 1. Have you any physical defect or infirmity? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Have you ever been declined or accepted on special terms for life, accident or illness insurance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Is your sight or hearing defective? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Do you intend to engage in hazardous sports or any other pastimes that expose you to extra personal injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you ever suffered from any nervous or mental condition, fainting episode, blackout, fit or paralysis of any kind? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates & Details to all "YES" answers to questions #1-7 _____ | |
| 4. Have you ever suffered from high blood pressure, a heart condition, rheumatic fever or diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |
| 5. Have you ever suffered from a "slipped disc" or other spinal disorder, a hernia or any rheumatic or arthritic condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |

DECLARATION

I declare that the above statements are true and complete, and that, apart from the matters declared above, I am in good health and ordinarily enjoy good health. I agree to the Underwriters obtaining medical information from any doctor who has attended me and authorize such doctor to give this information. I agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission. I understand that pre-existing conditions are not covered until a period of insurance of 12 months, treatment free, has elapsed.

Proposed Insured _____ Signature _____ Date _____

Policy Owner Signature (If other than the proposed Insured) _____ Date _____