



Amateur Sports Camps and Clinics Insurance Application

Name of Organization: _____

C/O (Individual Responsible for Insurance): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____ Fax: () _____

E-mail Address: _____

Program Coverage Summary

<u>Option #1 –</u>	<u>Option #2 –</u>
\$ 2,000,000 Aggregate per team, camp, or clinic	\$ 2,000,000 Aggregate per team, camp, or clinic
\$ 1,000,000 Personal and Advertising Injury	\$ 1,000,000 Personal and Advertising Injury
\$ 1,000,000 Each Occurrence	\$ 1,000,000 Each Occurrence
\$ 300,000 Damage to Rented Premises	\$ 300,000 Damage to Rented Premises
-Optional- Medical Exp	-Optional- Medical Exp
-Optional- Hired and Non-Owned Auto	-Optional- Hired and Non-Owned Auto
-Optional- Abuse and Molestation	-Optional- Abuse and Molestation
\$ 10,000 Accidental Death and Dismemberment	\$ 10,000 Accidental Death and Dismemberment
\$ 25,000 Participant Accident Medical	\$ 100,000 Participant Accident Medical
\$ 100 Deductible - Medical	\$ 100 Deductible – Medical

Additional Protection -

Abuse and Molestation –

This provides up to \$1,000,000 coverage to cover the cost of legal claims arising from alleged abuse and molestation. This coverage provides much needed protection for your organization.

Hired/Non-owned Auto –

Hired and Non-Owned Auto coverage provides up to \$1,000,000 of liability coverage for any vehicle under 10,000 lbs GRVW that is not owned by your organization but used in the course of organization business. This coverage is a must-have for any organization that relies volunteers to provide their own transportation. This coverage does not apply to rental vehicles or for vehicles used to transport participants.

Spectator Medical Payment Coverage –

Medical Payment Coverage provides up to \$5,000.00 per occurrence toward medical payments incurred by non-participants.

Option #1 Worksheet - \$25,000 Accident Medical						
	Number of Participants		Number of Days (or weeks)	Rate per Participant		Premium Due
Clinics/Day Camps (Excluding Cheerleading) - Daily		X	X	\$ 1.20	=	
Clinics/Day Camps (Excluding Cheerleading) – Weekly (3-7 consecutive days)		X	X	\$ 3.80	=	
Day Camps - Cheerleading		X	X	\$ 3.24	=	

Total Premium Due for Option #1 Coverage: \$ _____

Note: Minimum Premium is \$240.00

Option #2 Worksheet - \$100,000 Accident Medical						
	Number of Participants		Number of Days (or weeks)	Rate per Participant		Premium Due
Clinics/Day Camps (Excluding Cheerleading) - Daily		X	X	\$ 1.30	=	
Clinics/Day Camps (Excluding Cheerleading) – Weekly (3-7 consecutive days)		X	X	\$ 4.29		

Total Premium Due for Option #2 Coverage: \$ _____

Note: Minimum Premium is \$340.00

Additional Protection Worksheet

	Rate	=	Premium Due
Abuse and Molestation Coverage \$1,000,000	\$ 650.00	=	
Hired & Non-Owned Auto Coverage \$1,000,000	\$ 650.00	=	
Participant Medical Payment Coverage \$5000	\$ 65.00	=	

Requested Policy Period: From _____/_____/_____ through _____/_____/_____
 (mm/dd/yyyy) (mm/dd/yyyy)

ALL PREMIUMS ARE FULLY EARNED AT POLICY INCEPTION

Total Amount From Premium Due Columns: \$ _____

+

Application Fee: \$ 15

=

Total Amount Due For Premiums and Fees: \$ _____

Please circle your answer to all of the questions below:

- Does your team or organization adopt or adhere to rules and regulations created by a nationally recognized rule making organization? YES NO
- Do any covered activities involve pole-vaulting or any other track and field activity that involves thrown objects? YES NO
- Do any covered activities involve using a firearm that does not take place on a premises specifically designed for the purpose of discharging firearms? YES NO
- Have you or the team, league, or organization had any claims filed against it within the last four years? YES NO
- Is there an overnight exposure associated with the team, league, camp, or clinic? YES NO
- Do you require a completed waiver from all participants or agree to require the attached waiver? YES NO
- Is a parent's signature required for minors? YES NO
- Do you have a written incident report procedure in place? YES NO

If requesting Abuse and Molestation additional protection, please also answer all of the questions below:

- **Does your staff employment application include questions about whether the individual has ever been convicted of any crime?** **YES** **NO**
- **If permitted by state law, does your organization routinely request and receive background investigations for staff and volunteers?** **YES** **NO**
- **Do you verify employment related references and conduct personal interviews?**
YES **NO**
- **Do you have written procedures for dealing with sexual abuse?** **YES** **NO**
- **Has your organization ever had an incident that resulted in an allegation of sexual abuse?**
YES **NO**

Please sign and submit this application via mail, fax or e-mail along with payment by check for the above amount to:

**Commercial Risk Group, Inc.
1700 West Albany Suite #200
Broken Arrow OK 74012
Phone: 918-317-3200 Fax: 918-317-3205**

I confirm that all information provided on this application is true to the best of my knowledge and understand that any inaccurate or misleading statements may affect any claims made against the associated policy. I verify I have read and understand all information contained in this application and that Gagliardi Insurance Services reserves the right to deny all or part of any coverage offered. I understand that this application only provides a summary of coverage and that full details of the coverage or a copy of the insurance policies offered or purchased can be provided upon request. Insurance requirements may vary by venue and state. I understand that I am responsible for ensuring that I have purchased adequate coverage based on the location of the event or other covered activities.

Date: _____ Applicant Signature: _____

Print Name and Title: _____

Insurance services provided by:



Payment by credit card is optional. If desired, please complete and submit the credit card authorization form below:

Credit Card Authorization Form (*Visa or MasterCard Only*)

Name (as it appears on card):	
Billing Address:	
Billing City, State and Zip Code:	
Credit Card Number: (VISA OR MASTERCARD ONLY)	
Expiration Date:	
V Code: (3 number code on back of credit card)	
Amount to Be Billed: <small>(An Expedite Fee of \$100.00 will be charged if needed within 72 hours)</small>	
Billing Date:	
Additional Comments: (Name of Insured/League/ Organization)	

I, _____ (**please print**), authorize the use of my credit card described above for charges related to the services and products provided by Gagliardi Insurance Services, Inc.

Cardholder's Signature

Date

Commercial Risk Group, Inc. and
National Sports Insurance, Inc.
1700 West Albany Suite #200
Broken Arrow OK 74012
Phone: 918-317-3200 Fax: 918-317-3205

Additional Insured/Certificate Holder List
****Complete Address *MUST* be included for completion of certificate****

Certificate Holder

Address

City, State & Zip Code

Certificate Holder

Address

City, State & Zip Code

Certificate Holder

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➤ ***Attach additional list of certificate holders when necessary.***

