Coaches' Choice

YOUTH SPORTS CAMP & SPORTS CLINIC

Insurance Program and Enrollment Form

This brochure is valid for effective dates from 7/1/25 through 2/28/26

Higher liability limits are available immediately online at www.mycare26.com/specialty-programs

PROGRAM DESCRIPTION

This program has been designed for U.S. - based youth sports camp operations (those attended by campers age 19 or under) or sports clinics that are held at premises not owned or maintained by the sport camp operator. Coverage provided under this program includes important liability protection for the camp or clinic operator, including employees and volunteers, for liability claims arising out of its operations. In addition, the program provides medical payments coverage to the camp or clinic participants. Coverage is provided on an annual basis, but only applies to those camp/clinic sessions that are specifically reported.

Coverage is provided by a carrier rated A (Excellent) by A.M. Best Company.

INELIGIBLE OPERATIONS

Camps or clinics offering the following operations or instruction based on any of the following sport categories are not eligible for this insurance program. Please note, this is not a complete listing of ineligible sports. Please contact us for more information.

- After school/day care/latch key programs
- All star/bowl games*
- Hunting and/or nature camps/programs
- Pop Warner Little Scholars Football or Cheer Camps/Clinics
- Pro-sport try-out and training camps
- Recruiting camp/event, ID camp, showcase, or combine*
- Sports camp/clinic operators who own or maintain their own facility
- Weight loss camps/programs
- 100% virtual camps/operations

- Boxing
- Box lacrosse
- Broomball
- Cycling or BMX
- Diving
- Equestrian
- Martial arts - all styles
- Open water activities/events
- Roman/Greco Wrestling
- Skiing (snow or water)

* Please contact us for programs that can provide coverage for these types of operations

ELIGIBLE OPERATIONS

Sports operations conducted on a clinic, day camp or overnight camp basis for attendees age 19 and under that are focused on improving skills in one of the following sport categories are eligible for this insurance program. If your sport is not listed, please contact us to confirm eligibility.

- Day camps/clinics for youth with an accompanied adult are eligible for this program (e.g.: parents and me camps). Ratios cannot be more than 2 adults per child

- Classroom/lecture clinics for coaches or officials in any of the above mentioned sports are also eligible to enroll in this insurance program

Class 1 Sports:

- Baseball
- Basketball
- Drill team
- Golf
- Softball
- Squash
- Swimming
- Strength and conditioning
- Tennis
- Track & field
- Volleyball
- Water polo

Class 2 Sports:

- Cheerleading
- Deck/floor/street hockey
- Field hockey
- Football
- Gymnastics
- Ice hockey
- Inline hockey
- Lacrosse
- Roller hockey (quad)
- Soccer
- Water hockey
- Wrestling

EASY WAYS TO ENROLL FOR COVERAGE

WEB For information and applications, visit us on-line at **www.mycare26.com/specialty-programs**

OR

Submit this enrollment form, with payment, to us.

FAX 1-913-754-5617

MAIL Academic HealthPlans, Inc.,
PO Box 736073
Chicago, IL 60673-6073

QUESTIONS Call 1-**913-754-5617**

FOR SERVICE REQUESTS ONLY

E-MAIL
recsportsandmore@recsportsandmore.ahpcare.com

COVERAGES AND LIMITS Coverage is not available for Alaska and Rhode Island Applicants		
Coverages	**Option 1**	**Option 2**
Commercial General Liability (CGL): Each Occurrence Limit	**Limits** $ 1,000,000	**Limits** $ 2,000,000
General Aggregate Limit (other than Products-completed Operations) – per event/camp	$ 5,000,000	$ 5,000,000
Products-completed Operations Aggregate	$ 1,000,000	$ 2,000,000
Personal and Advertising Injury Limit	$ 1,000,000	$ 2,000,000
Professional Liability Limit	$ 1,000,000	$ 2,000,000
Hired Auto Liability Limit	$ 1,000,000	$ 2,000,000
Non-Owned Auto Liability Limit	$ 1,000,000	$ 2,000,000
Damage to Premises Rented to You Limit (Fire Legal Liability)	$ 1,000,000	$ 1,000,000
Medical Expense Limit (other than participants)	$ 5,000	$ 5,000
Medical Payments for Participants (excess) $100 per claim deductible applies	$ 25,000	$ 250,000
Legal Liability to Participants Limit (LLP)	$ 1,000,000	$ 2,000,000

Rates (per participant) NOTE: If multiple sports are in a single camp, then the highest sport class applies		
Class 1 Sports	**Option 1**	**Option 2**
Per participant/per daily session	$1.45	$1.97
Per participant/per weekly session (camps 3-7 consecutive days)	$4.33	$5.99
Per participant/overnight camps (camps no more than 7 consecutive days) Note: Adult accompanied camps are not eligible for this option	$5.75	$7.95
Class 2 Sports	**Option 1** with Limited Neurodegenerative Injury Coverage*	**Option 2** with Limited Neurodegenerative Injury Coverage*
Per participant/per daily session	$1.60	$2.20
Per participant/per weekly session (camps 3-7 consecutive days)	$4.78	$6.66
Per participant/overnight camps (camps no more than 7 consecutive days) Note: Adult accompanied camps are not eligible for this option	$6.34	$8.83
Minimum Premiums	$ 240.00	$ 360.00

*LIMITED NEURODEGENERATIVE INJURY COVERAGE - Neurodegenerative Injury to Specified Players for Sports or Athletic Activities “Neurodegenerative injury” means any brain injury, neurological injury, disease, condition or dysfunction, including, but not limited to, Alzheimer’s disease, Parkinson’s disease, amyotrophic lateral sclerosis (ALS), mild traumatic brain injury, repetitive brain trauma, chronic traumatic encephalopathy (CTE), dementia, cognitive injury or disorder, memory loss, anxiety disorder, mood disorder, depression, sleeplessness, impulse control problems, headaches or single or repetitive concussive or sub-concussive injury or trauma.

Neurodegenerative Injury limit / Aggregate limit	$ 1,000,000 / $ 1,000,000
Neurodegenerative Injury Supplementary Payments limit/Aggregate limit	$ 1,000,000 / $ 1,000,000

COVERAGES AND LIMITS CONTINUED

Commercial General Liability with Broadening Endorsement - coverage which protects the insured against liability claims for bodily injury and property damage arising out of premises, operations, products and completed operations and personal and advertising injury. Legal liability to participants and professional liability coverage are also provided as part of this program. No deductible applies to liability claims.

Hired Auto and Non-Owned Auto Liability - coverage which protects the insured against liability claims arising out of the maintenance or use of motor vehicles hired, leased, rented, or borrowed by the insured on a short-term basis, as well as coverage for those autos your organization does not own, lease, hire, rent or borrow that are used in conjunction with your operations. Coverage does not extend to the transporting of participants, or the use of multi-passenger vehicles (designed to carry 9 or more persons), or to those vehicles that are rented, hired or borrowed on a long-term basis.

Medical Payments for Participants - coverage which pays the medical and dental expenses incurred by a "participant" when an accidental injury occurs while participating in your camp operations. The coverage is provided on an excess basis, responding after all other medical coverage available to the "participant" has been exhausted. If no other medical coverage exists, the coverage becomes primary. A $100 deductible applies to each claim and the benefit period is two years from the date of the accident.

EXCLUSIONS

The following represent only some of the exclusions contained in this policy.

- Sexual abuse or sexual molestation (unless reported to, approved by us, and appropriate premium paid)
- Amusement devices (e.g.: rides, slides, inflatables, bungees, climbing walls, dunk tanks)
- Asbestos and silicosis
- Communicable disease
- Cryogenic chambers/therapy
- Employment-related practices
- Fireworks
- Fungus
- Lead
- Operation, maintenance or management of any facility or field other than being used for covered activities
- Nuclear energy
- Operations listed as ineligible
- Perfluoroalkyl and polyfluoroalkyl substances (PFAS)
- Total Pollution
- Transportation of participants and use of multi-passenger vehicles
- Use of haunted attractions

OPTIONAL COVERAGE AVAILABLE

Sexual Misconduct Liability OR Abuse, Molestation, Harassment or Sexual Conduct Defense Costs Reimbursement

This program includes two options for coverage for claims arising out of sexual misconduct:

Option 1: $250,000 each "Insured Event" limit with a $1,000,000 aggregate limit of liability for sums the insured becomes legally obligated to pay as damages because of loss arising out of any actual, alleged, or threatened sexual misconduct. This limit is part of, not in addition to, the general liability limit selected.

Option 2: $100,000 of coverage for reimbursement of defense costs only resulting from claims arising out of abuse, molestation, harassment or sexual conduct.

Coverage Conditions:

1. Coverage is contingent upon completion, as well as review and approval from us, of the underwriting questions found on page 9.
2. Coverage is not available on a stand-alone basis. You must have commercial general liability coverage for your camp or clinic with our Youth Sports Camp and Sports Clinic RPG Insurance Program.
3. Only one option may be purchased.

Options	Rates
Option 1 **Sexual Misconduct Liability** (defense expense within limits) $250,000 each "Insured Event" limit/$1,000,000 aggregate	Daily Rate - $.15 per camper Weekly Rate - $.45 per camper Overnight/Resident Rate - $.59 per camper ($150.00 minimum premium)
Option 2 **Abuse, Molestation, Harassment or Sexual Conduct Defense Costs Reimbursement** $100,000 limit	$100.00 (Flat rate)

FREQUENTLY ASKED QUESTIONS

1. **When should I make my coverage effective?**
   The effective date is the date you need your insurance to start. For many, this is the first day of the camp/clinic or when you begin setting up. If you are renewing coverage with us, use the expiration date of your coverage.

2. **How do I calculate the premium? What is a minimum premium?**
   Premium is based on the actual or maximum number of campers expected times a rate. A minimum premium is the amount you must pay if your calculated premium is less than the minimum premium for the option you choose.

   Example: A 2 day clinic, class 1 sport, that needs $1,000,000 in coverage for 50 campers:
   Step 1: Choose Option 1
   Step 2: Take the daily session rate for Option 1, which is $1.45 x 50 x 2 for a premium calculation of $145.00.
   Step 3: Since the premium calculation is below the $240.00 minimum premium for Option 1, the total premium due for this clinic is $240.00.

3. **What if I have multiple camps or clinics scheduled and I am not sure how many participants will attend these camps or clinics? What do I report?**
   At the time of enrollment, please provide us a list of all your known camps or clinics. Use the maximum amount of campers that your camp/clinic can accommodate to calculate the premium due. TBD numbers will not be accepted.

4. **What do I do if I add a camp or clinic after I submit my enrollment?**
   To provide coverage for a new camp/clinic not previously reported, you must inform us in writing of the new dates by completing a youth camp/clinic supplemental request form prior to the start date of the camp/clinic along with any additional premium due. Camps or clinics not reported to us prior to occurring will not be covered.

5. **How do I report cancellations, changes or any additional camps after hours or on a weekend?**
   Since any changes to your coverage need to be reported prior to the scheduled start date or the first day of camp and be submitted in writing, please either fax or e-mail us the necessary change as soon as you can. If you do not have access to fax or e-mail, please leave us a voicemail message and follow up with written confirmation as quickly as possible.

6. **Will I receive a policy after I submit the enrollment form?**
   No. You will receive a certificate of insurance as proof of coverage. By applying for this insurance, you are applying for membership in the Sports, Leisure and Entertainment Risk Purchasing Group (RPG), a group formed and operating pursuant to the Liability Risk Retention Act of 1986 (15 USC 3901 et seq.). Coverage is offered exclusively through the Sports, Leisure and Entertainment Risk Purchasing Group (RPG). The RPG receives a master policy from the insurance company. Submission of this enrollment form confirms your desire to receive coverage through the RPG. Each member receives their own certificate of insurance as evidence of coverage. The limits of insurance apply individually to each insured member organization - there are no shared limits of liability with any other members. For a copy of the RPG master policy, please submit your request in writing to: Academic HealthPlans, Inc., PO Box 736073 Chicago, IL 60673-6073 or recsportsandmore@recsportsandmore.ahpcare.com.

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Enrollment Form - Youth Sports Camp & Sports Clinic Insurance

Valid for effective dates from 7/1/25 through 2/28/26

Completion of this enrollment form confirms your desire to obtain insurance through the Sports, Leisure and Entertainment Risk Purchasing Group, a group formed and operating pursuant to the Liability Risk Retention Act of 1986 (15 USC 3901 et seq.). A risk purchasing group (RPG) provides group purchasing power for similar risks resulting in potential advantageous coverage terms, and competitive rates for favorable group loss experience. An RPG administration fee may be charged. The submission of this enrollment form and/or the acceptance of payment does not guarantee coverage. Certain operations are not eligible for coverage by this program and submissions with a premium of $25,000 or more are subject to additional underwriting. We reserve the right to decline any request for coverage.

TO AVOID PROCESSING DELAYS: 1. Complete all sections (print legibly) 2. Sign and date where required
3. Remit completed enrollment form (pages 5 - 15)
***New York and Wyoming Applicants must also submit page 17 or 18**

NOTE: Coverage is not available for Alaska and Rhode Island Applicants

GENERAL INFORMATION

Full legal name of business: _____

Note: This is the name that will appear on your Certificate of Insurance. If your company is a Sole Proprietorship, then this will be your personal name or DBA.

Applicant is a: ❍ Sole Proprietorship ❍ Limited Liability Co. ❍ Corporation ❍ Partnership
❍ Other (describe): _____

Form of business/organization: ❍ Not-for-profit ❍ For-Profit

Mailing address: _____

NY Applicants must provide a street address. PO Boxes cannot be accepted.

City: _____ State: _____ Zip: _____

Contact name: _____ Phone: (_____) _____

Cell: (_____) _____ Fax: (_____) _____

E-mail: _____ Website: _____

(By listing an email address, you are giving us permission to contact you by email about your policy. Refer to page 11 of the application for Electronic Disclosure and Consent)

DATES

❍ **I am a new account**

Start my coverage on this date ____/____/____

Coverage will begin the day after a completed and signed enrollment form with payment is received and approved by us, or on a later date you specified above.

❍ **I am renewing my coverage**

Expiration date of current coverage ___/___/___ Renew my coverage on this date ___/___/___

To avoid a coverage gap, please make sure you have submitted a completed and signed enrollment form with payment prior to your expiration date.

NOTE: **If you need coverage bound as of today**, please read the statement below and confirm by checking the box that you have not had any losses. Please note, for coverage to be considered you MUST submit a completed and signed application submitted with payment. Submission of this form does not guarantee coverage. We reserve the right to decline requests.

❍ I hereby certify that I, or any person or organization to be covered by this insurance, are not aware of any losses, accidents, or circumstances, occurring on this day that might give rise to a claim under this insurance.

BUSINESS INFORMATION

1. Are any of your camp/clinic attendees age 20 or over?	❍ Yes	❍ No
If yes, do you allow more than two parents or adults to accompany youth participants in camp activities?	❍ Yes	❍ No
If you allow parent or adult participation, do you offer any "adult-only" instruction or competitions?	❍ Yes	❍ No
2. Are you an after school, day care or latch key program?	❍ Yes	❍ No
3. Do you own or maintain the facility(s) where the camps/clinics take place?	❍ Yes	❍ No
4. Are you a weight loss camp/program?	❍ Yes	❍ No
5. Does any of your camps/clinics include an all star game or bowl game?	❍ Yes	❍ No

BUSINESS INFORMATION CONTINUED

6. Are any of your camps/clinics a professional try-out or training camp? ❍ Yes ❍ No
7. Are any of your camps/clinics an ID camp, recruiting camp/event, showcase, or combine? ❍ Yes ❍ No
8. Are any of your camps/clinics held on the property of a private home or residence? ❍ Yes ❍ No
9. Does your program include any trips away from the main location? ❍ Yes ❍ No
   If yes, please submit additional details. Trips made away from the main location must be reported prior to occurring, and approved by us.

The exposures/activities listed above are not covered by this program and any resulting claims will be denied. If you wish to cover any of these activities, please contact us to determine if other coverage options are available.

10. Are any of your camps/clinics by invitation only? ❍ Yes ❍ No
11. Is this a Pop Warner Little Scholars football or cheer camp/clinic? ❍ Yes ❍ No
12. Do you have concussion management protocols/guidelines that are consistently enforced and includes communication (in written or electronic form) of education materials to participants, parents and coaches about the nature of risk of concussions including but not limited to information such as focusing on prevention and preparedness to keep athletes safe; understanding concussions and potential consequences of the injury; recognizing concussion symptoms and how to respond; and learning about steps for returning to play after suspected concussion? ❍ Yes ❍ No
13. If you suspect an athlete has a concussion, do you have an action plan that includes:
    - Immediately removing the athlete from play or practice ❍ Yes ❍ No
    - Keeping the athlete out of play or practice until they provide written clearance from a licensed physician ❍ Yes ❍ No
    - Confirming sports liability waivers (informed consent) from parents and/or players are secured ❍ Yes ❍ No

RATES AND MINIMUM PREMIUMS

Class 1 Sports		
Type of Camp Sessions	**Option 1 $1,000,000 CGL and $25,000 MPP**	**Option 2 $2,000,000 CGL and $250,000 MPP**
Daily (no overnight exposures) • 2 consecutive days or less; OR • Multiple non-consecutive days	$1.45 Per Day/Per Commuter Camper	$1.97 Per Day/Per Commuter Camper
Weekly (no overnight exposures) • 3-7 consecutive days	$4.33 Per Week/Per Commuter Camper	$5.99 Per Week/Per Commuter Camper
Overnight/Resident • 1-7 consecutive days Note: Adult accompanied camps are not eligible for this option	$5.75 Per Resident Camper	$7.95 Per Resident Camper
MINIMUM PREMIUMS:	$240.00	$360.00

Class 2 Sports		
Type of Camp Sessions	**Option 1 $1,000,000 CGL and $25,000 MPP** with Limited "Neuro" Injury Coverage	**Option 2 $2,000,000 CGL and $250,000 MPP** with Limited "Neuro" Injury Coverage
Daily (no overnight exposures) • 2 consecutive days or less; OR • Multiple non-consecutive days	$1.60 Per Day/Per Commuter Camper	$2.20 Per Day/Per Commuter Camper
Weekly (no overnight exposures) • 3-7 consecutive days	$4.78 Per Week/Per Commuter Camper	$6.66 Per Week/Per Commuter Camper
Overnight/Resident • 1-7 consecutive days Note: Adult accompanied camps are not eligible for this option	$6.34 Per Resident Camper	$8.83 Per Resident Camper
MINIMUM PREMIUMS:	$240.00	$360.00

CAMP INFORMATION

1. Please list all camp sessions individually below.

Type of Camp Sessions
Daily (no overnight exposures) = 2 consecutive days or less; OR Multiple non-consecutive days
Weekly (no overnight exposures) = 3-7 consecutive days (max 7 consecutive days)
Overnight/Resident (Note: Adult accompanied camps are not eligible for this coverage) = 1 – 7 consecutive days

2. **Coverage only applies to those camp sessions specifically reported and each session must be individually listed.**
3. Should you have more than 4 camps, please provide information on an additional sheet.

CAMP/SESSION #1

Name of Camp: _____

Type of camp (list type(s) of sport(s)/activity(s): _____

Dates of camp: _____/_____/_____ to _____/_____/_____ Hours of operation: _____A.M./P.M. to _____A.M./P.M.

Camp days (circle all that apply): Mon Tues Wed Thurs Fri Sat Sun

Camp Location(s) _____

# of youth campers/participants (below age 19): _____ # of adult campers/participants: _____

Check all that apply: ❍ Daily ❍ Weekly ❍ Overnight/Resident ❍ Virtual

CAMP/SESSION #2

Name of Camp: _____

Type of camp (list type(s) of sport(s)/activity(s): _____

Dates of camp: _____/_____/_____ to _____/_____/_____ Hours of operation: _____A.M./P.M. to _____A.M./P.M.

Camp days (circle all that apply): Mon Tues Wed Thurs Fri Sat Sun

Camp Location(s) _____

# of youth campers/participants (below age 19): _____ # of adult campers/participants: _____

Check all that apply: ❍ Daily ❍ Weekly ❍ Overnight/Resident ❍ Virtual

CAMP/SESSION #3

Name of Camp: _____

Type of camp (list type(s) of sport(s)/activity(s): _____

Dates of camp: _____/_____/_____ to _____/_____/_____ Hours of operation: _____A.M./P.M. to _____A.M./P.M.

Camp days (circle all that apply): Mon Tues Wed Thurs Fri Sat Sun

Camp Location(s) _____

# of youth campers/participants (below age 19): _____ # of adult campers/participants: _____

Check all that apply: ❍ Daily ❍ Weekly ❍ Overnight/Resident ❍ Virtual

CAMP/SESSION #4

Name of Camp: _____

Type of camp (list type(s) of sport(s)/activity(s): _____

Dates of camp: _____/_____/_____ to _____/_____/_____ Hours of operation: _____A.M./P.M. to _____A.M./P.M.

Camp days (circle all that apply): Mon Tues Wed Thurs Fri Sat Sun

Camp Location(s) _____

# of youth campers/participants (below age 19): _____ # of adult campers/participants: _____

Check all that apply: ❍ Daily ❍ Weekly ❍ Overnight/Resident ❍ Virtual

COST CALCULATION

Important Information and Cost Calculation:

1. Use rates on page 6 to calculate premium. Premium is determined by applying the appropriate rate for the coverage option selected to the maximum amount of expected campers/participants. Day camps/clinics with an accompanied adult(s) need to count all participants in their program including the adults. TBD cannot be accepted.
2. If calculated premium is less than minimum (see chart on page 6), use the minimum premium.
3. The same limit option must be used for all camps.
4. If multiple sports are in a single camp, then the highest sport class applies
5. OPTIONAL LIMITS AVAILABLE – For liability limits of $3,000,000, $4,000,000 and $5,000,000. Visit us online for an immediate quote or check here if a higher liability limit is needed.
   ❍ Limit needed:_____
6. Costs are 100% non-refundable/non-transferrable once coverage begins. Coverage is contingent upon receipt of payment and a fully completed enrollment form. No coverage will be deemed in effect until accurate payment is received by the company or their representative.

NOTE: <u>Cancellations must be reported prior to the scheduled start date or the first day of the camp/clinic session</u>, and confirmed in writing for a refund or credit to be considered. Refunds may be subject to a cancellation penalty. Cancellations/changes can only be made by the named insured.

Camp/Session # (from page 7)	**Coverage Option** (1 or 2)	**# of Days OR Weeks**	**X**	**Daily OR Weekly Rate** (from page 6)	**X**	**# of Campers**	**=**	**Premium**
			X	$	X		=	$
			X	$	X		=	$
			X	$	X		=	$
			X	$	X		=	$
			X	$	X		=	$
			X	$	X		=	$
			X	$	X		=	$
			X	$	X		=	$
			X	$	X		=	$
Calculated Premium (add premium lines above)								$ (A)
Minimum Premium (from page 6) • **Option 1 minimum premium = $240** • **Option 2 minimum premium = $360**								$ (B)
Program Premium Due (greater amount from line A or B)								$

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E-mail = recsportsandmore@recsportsandmore.ahpcare.com • Fax 1-913-754-5617
www.mycare26.com/specialty-programs
CA # 0H64806, TX # 1554208, FL # L074590

OPTIONAL COVERAGES PREMIUM CALCULATIONS

Sexual Misconduct Liability Coverage OR Abuse, Molestation or Harassment or Sexual Conduct Defense Costs Reimbursement

Coverage is contingent upon underwriting review and approval of the following questionnaire.

❍ **Check here and skip this section if you do not want this coverage option**

1. Does your organization currently have employees, volunteers or independent contractors? ❍ Yes ❍ No
   The term "Volunteers" means someone, including parent volunteers, who exerts control over or supervises participants.
2. Have any claims, allegations or charges of abuse, molestation or sexual misconduct been made against you or your organization or anyone working on behalf of your organization? ❍ Yes ❍ No
   If yes, please explain: _____
3. Are you aware of any occurrences that could lead to a claim? ❍ Yes ❍ No
   If yes please explain: _____
4. Do you, your organization or sanctioning/governing body have written procedures and training in place regarding the prevention and mitigation of abuse, molestation, or sexual misconduct? ❍ Yes ❍ No
   If yes, do they include:
   - How to recognize the signs of abuse and molestation ❍ Yes ❍ No
   - All known, alleged or suspected abuse incidents must be reported to law enforcement ❍ Yes ❍ No
   - Procedures are provided or available to all paid and volunteer staff, and sanctioning/governing body members ❍ Yes ❍ No
   - No one-on-one situations allowed without visibility by others ❍ Yes ❍ No
   - A supervision plan to monitor all participants at the facility/event site that also prevents access to secluded area such as closets, unsupervised rooms, etc. ❍ Yes ❍ No
   - A policy regarding appropriate and inappropriate physical contact, verbal interaction and electronic communications with children during and outside of regularly scheduled business activities ❍ Yes ❍ No
5. Please complete the following questions regarding employee, volunteer, or independent contractor screening controls used by your organization.

Please Complete All Questions The term "Volunteers/Independent contractors" in the following questions means someone who exerts control over or supervises participants.	**Employees**	**Volunteers/Independent contractors**
Do you have employees and/or volunteers/independent contractors?	❍ Yes ❍ No	❍ Yes ❍ No
Are employee/volunteer/independent contractor applications required?	❍ Yes ❍ No	❍ Yes ❍ No
If yes, does the application include questions about whether the individual has ever been convicted for any crime involving physical violence or sex related offenses?	❍ Yes ❍ No	❍ Yes ❍ No
If yes and applicant checks yes, do you reject the applicant?	❍ Yes ❍ No	❍ Yes ❍ No
Are background checks provided by a third party vendor/service?	❍ Yes ❍ No	❍ Yes ❍ No
If yes, do you reject an applicant with any history of physical violence or sex related offenses?	❍ Yes ❍ No	❍ Yes ❍ No

Please explain any "No" responses to questions asked in #5: _____

6. Calculate premium

❍ **Option 1 - Sexual Misconduct Liability** ($250,000 each "Insured Event"/$1,000,000 aggregate)
Rates: Daily Rate = $.15 Weekly Rate = $.45 Overnight/Resident Rate = $.59

Camp/Session # (as reported on page 8)	**# of Days OR Weeks**	**X**	**Daily OR Weekly Rate** (from above)	**X**	**# of Campers**	**=**	**Premium**
		X	$	X		=	$
		X	$	X		=	$
Add all lines above for calculated premium							$
Option 1 Total Premium - Calculated premium total from line above OR $150.00 minimum premium – whichever amount is higher							$
❍ **Option 2 - Abuse, Molestation, or Harrassment of Sexual Conduct Defense Costs Reimbursement** ($100,000 limit)							$ 100.00

CERTIFICATE REQUESTS

Once your enrollment form is approved, you will receive a Certificate of Insurance as evidence that coverage is bound. **Complete this section if you require additional certificates listing a facility, property owner or similar third-party as an additional insured on your policy. Provide a separate request for each additional certificate needed.**

Note: Please request all additional insureds needed for this policy term. Additional insureds from the expiring policy term will not be automatically renewed.

1. Camp #:_____

2. When is this certificate needed? : _____/_____/_____

3. What is the additional insured's relationship to you?

❍ Owner/manager/lessor of premises (facility or venue) ❍ Sponsor ❍ Co-promoter

❍ Other (please identify/explain):_____

NOTE: The certificate holder will automatically be an Additional Insured for an Owner/manager/lessor, Sponsor or Co-Promoter relationship

4. Certificate holder/additional insured name:_____

Mailing address: _____

City: _____ State: _____ Zip:_____

5. Does the certificate holder/additional insured require any special wording or endorsements? ❍ Yes ❍ No

If yes, check all that apply: ❍ CG2026 ❍ Primary ❍ Waiver of subrogation

❍ Other (please explain): _____

NOTE: If you are not sure, please attach a copy of the insurance requirements/instructions you've received.

The most common delay in certificate processing is caused by providing partial or incorrect name and/or instructions. Please check your request carefully before submitting.

COVERAGE EXCLUSIONS

The following notable exclusions are contained in the commercial general liability coverage provided by this program.
Sexual abuse or sexual molestation (unless reported to, approved by us, and appropriate premium paid); Access or disclosure of confidential or personal information and data-related lability – with limited bodily injury exception; Ancillary activities/trips held away from the reported camp/clinic location unless supervised, approved and on file with the company; Asbestos and silicosis; Cannabis; Certain computer-related losses; Commercial general liability standard exclusions (CG0001 04/13 edition); Communicable disease; Cryogenic chambers/therapy; Employment-related practices; ERISA; Fireworks; Fungus; Lead; Nuclear energy; Operation, maintenance, ownership, or management of any athletic facility or field, other than while being used for covered activities; Operations of independent concessionaires, exhibitors and vendors in conjunction with your organization; Perfluoroalkyl and polyfluoroalkyl substances (PFAS); Radioactive matter; Specified recreational vehicles and activities: Aircraft/hot air balloon; Airport; Amusement devices (The ownership, operation, maintenance or use of: any device or equipment a person rides for enjoyment, including, but not limited to, any mechanical or non- mechanical ride, slide, water slide (including any ski or tow when used in connection with a water slide), moonwalk or moon bounce, bungee operation or equipment or inflatable recreational device. Amusement device also includes any vertical device or equipment used for climbing—either permanently affixed or temporarily erected. Amusement devices does not include any video arcade or computer game or any device that is specifically designed for the training or instruction of the activity for which you are enrolled.); Dunk tanks; Haunted attraction, Animals (injury or death to any animal; or injury death, or property damage caused by any animal owned, rented, or hired by you); Performer; Rodeo; Saddle animal; Snowmobile; Transportation of participants (Bodily injury to participants while in a hired auto or non-owned auto); Total pollution; Use of multi-passenger vehicles; Those operations listed as ineligible: After school, day care and latch key programs; All star/bowl games; Hunting and/or nature camps/programs; Pro-sport try-out and training camps; Recruiting camps/events, ID camps, showcases, or combines; Sports camp/clinic operators who own or maintain their own facility; 100% virtual camps/operations; Weight loss camps/programs; Sports camps/clinics offering instruction of: Adventure races; Bandy; Biathlon; Bobsled; Body boarding; Boxing; Box lacrosse; BMX or stunt cycling; Broomball; Canoeing; Climbing; Cycling; Diving; Dodgeball; Equestrian; Hang gliding; Hammer throw; Highland games; Hostelling; Hurling; Inline (extreme, aggressive, freestyle) skating; Inline Stunt performing; Jai alai; Javelin; Kayaking; Kite surfing; Luge (street); Marathon; Martial arts - all styles; Modern pentathlon; Mountain biking and/or hiking; Mountain boarding; Open water activities/events; Orienteering; Outrigging; Parachute; Parasailing; Polo (horse), Rafting; Rodeo; Roller derby; Rowing/Crew; Rugby; Sailing; Scuba diving; Shooting sports/events; Skateboarding; Skiing (snow or water); Sky diving; Sky surfing; Sled/Crew dog racing; Snorkeling; Snowboarding/snow surfing; Sports parachuting; Streetball; Surfing (including boogie boards); Trapeze; Takraw; Trampoline (unless reported, reviewed and approved by us); Triathlon; Unicycling; Wake boarding; Wind surfing; Wrestling (Roman/Greco); Yachting.

IMPORTANT. PLEASE READ.

Surplus Lines Disclosure

The commercial general liability insurance policy is being placed in your home state as surplus lines coverage under the Nonadmitted Insurance Model Act. The insurer with which such policy is placed is not licensed in your home state and is not subject to its supervision. The insurer is an eligible Surplus Lines Insurer. Policies placed with eligible surplus lines insurers are not subject to the rate and form review of any Insurance Department and there is no protection afforded under the provision of any state insurance guaranty association for this policy.

Premium figures do not include surplus lines taxes and fees.

Please see the Member Certificate issued to you for important notices related to surplus lines insurance required by your home state and the exact amount of the applicable surplus lines taxes and fees.

The insurance company is rated A (Excellent) by AM Best Company with financial size category of XV ($2 Billion or Greater)

IMPORTANT INFORMATION. PLEASE READ.

PLEASE READ AND COMPLETE THE BELOW,

if you do not wish to receive documents via email and prefer another method of document delivery

Consent for Electronic Transactions

The Electronic Signatures in Global and National Commerce Act provides that a signature, contract or other record may not be denied legal effect, validity or enforceability solely because it is in electronic form or because an electronic signature was used in a transaction.

As part of your participation in this program you will receive all documentation, including but not limited to, the insurance quotes, policies, certificates, endorsements, and invoices (if applicable), by electronic means. If permitted by your state, you may also receive conditional renewal notices, cancellation, or non-renewal notices via electronic delivery.

To obtain, download, and view all policy documentation electronically you must have the following hardware or software in place.

- A personal computer capable of receiving, accessing, and displaying or printing or storing communications and documents received in an electronic form.
- Adobe PDF Reader version
- System requirements: OC: Windows 7 or higher, Internet Explorer v11 or higher, Firefox v45.7 or higher, Chrome v40 or higher; OS: Mac OS x 10.9 or higher, Safari 9.0 or higher, Firefox v45.7 or higher, Chrome v40 or higher.

By agreeing to receive documents electronically, you are affirming that your computer system meets the hardware and software requirements for receiving all related documents. If documents are provided through a website or portal, you should download and store all such documents. For persons who receive electronic documents via email, these documents will be delivered to the email address on file. Upon receipt of your emailed documentation please save a copy on your own device.

You agree to notify us promptly if your mailing address, e-mail address or other delivery information changes by calling 1-913-754-5617 or mailing us at Academic HealthPlans, Inc., PO Box 73607, Chicago, IL 60673-6073.

We will endeavor to provide a notice to you in the event of any changes regarding hardware or software requirements necessary to receive documents and other related documents electronically. However, it is your duty to notify us if you are unable to access the documentation made electronically available to you.

We may at our sole discretion discontinue availability of electronic delivery at any time, without further notice to you. At any time, you may request a paper copy of your documents in lieu of electronic delivery. You may withdraw your consent to receive electronic documentation by sending a request in writing to us at Academic HealthPlans, Inc., PO Box 73607, Chicago, IL 60673-6073. Until receipt of such withdrawal, you will continue to receive all documentation electronically.

This consent is voluntary, by accepting, you signify that you consent to these terms of electronic document delivery via email or other electronic media in connection with your insurance documents, whether such delivery is made on its own behalf and/or on behalf of an organization or other third party. You further represent and warrant that if consenting on behalf of an organization or third party, you have the requisite authority to provide such consent, and that you and the organization have the requisite hardware and software to receive and acknowledge receipt of electronically delivered Documents.

After this enrollment form is approved, you will receive a certificate of insurance showing evidence that coverage has been bound. When submitted through an insurance agent or broker, this coverage document will only be delivered to them. Additional certificate requests will be issued to the same person. Providing an email address in this application will be deemed consent to us to deliver documents and communication to you electronically.

I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY. SUCH ELECTRONIC MAILING OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES.

If you DO NOT want to be emailed, please check here and select your preferred method of document delivery. ❍

❍ Fax to: _____ Attn: _____

❍ Mail to: _____ Attn: _____

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME, AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ALABAMA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION, FINES, OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND, AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE THAT SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

FRAUD WARNING (continued)

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME, AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAYBE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

AGENT INFORMATION

AGENTS: Please complete the information below.

AGENTS: YOU MUST COMPLETE THIS SECTION to be recognized as the broker on this account.

Agency name:_____ Agent/contact name: _____

Agency complete mailing address: _____

Agency telephone: (_____) _____ Agency fax: (_____) _____

Agent/contact e-mail address: _____ Tax I.D. _____

I represent and warrant as an insurance producer that I currently maintain, and will maintain, all individual, corporate or agency licenses or permits to conduct insurance business in the state coverage for this insured is being written. I further represent and warrant that I currently maintain errors and omissions insurance with a minimum limit of $1,000,000 for myself, my officers, and employees. If requested by the company, I will provide them with reasonably satisfactory evidence of all of the above mentioned items.

I understand that agents do not have authority to issue binders or a certificate of insurance on behalf of this program.

Agent signature: _____ **Date:** _____

IMPORTANT ITEMS TO NOTE

Costs are 100% fully earned and non-refundable/non-transferrable once coverage begins. Coverage is contingent upon receipt of payment and a fully completed enrollment form. No coverage will be deemed in effect until the accurate payment and a completed enrollment form is received by the company or their representative.

Cancellations must be reported prior to the scheduled start date or the first day of the camp/clinic session, and confirmed in writing for a refund or credit to be considered. Refunds may be subject to a cancellation penalty. Cancellations/changes can only be made by the named insured.

Changes to your coverage need to be reported prior to the scheduled start date or the first day of camp and be submitted in writing, please either fax or e-mail us the necessary change as soon as you can. If you do not have access to fax or e-mail, please leave us a voicemail message and follow up with written confirmation as quickly as possible.

PLEASE READ AND SIGN.

Warranty and Disclosure Statement: I understand that the insurance company, in determining whether to provide insurance coverage, will rely on the information contained in this form and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct and that this policy is 100% non-refundable/non-transferrable once coverage begins.

I am aware that the insurance company expects accurate reporting for my premium calculation. I understand that my book and records may be examined or audited by the insurance company at any time during the coverage period and up to three years thereafter. Intentional misrepresentation or misreporting may jeopardize coverage. We reserve the right to decline/void any ineligible coverage.

I further acknowledge that, I have reviewed all information provided with this enrollment form and understand the exclusions which apply, as well as the activities and operations for which coverage is not provided and that this policy is 100% non-refundable/non-transferrable once coverage begins.

Applicant business name (from page 5): _____

Applicant or agent signature: _____ **Date:** _____

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. By selecting 'Yes' and typing my name above, I am electronically signing the application and agreeing to the terms and conditions stated in the AHP Consent for Electronic Transactions ❍ Yes ❍ No

Printed name: _____ **Title:** _____

If an agent: Check here to acknowledge you are signing on behalf of the named insured ❍

AGENTS: PLEASE MAKE SURE YOU COMPLETE THE AGENT WARRANTY SECTION ABOVE

Enrolllments cannot be accepted unless this section is completed

FINAL PAYMENT CALCULATION AND PAYMENT OPTIONS

(Certain operations are not eligible for coverage by this program and submissions with a premium of $25,000 or more are subject to additional underwriting. We reserve the right to decline any request for coverage.)

Step 1: Applicant Business Name from page 5_____

Step 2: Enter Program Premiums:

Liability Premium (required coverage) from page 8 $_____(a)

Sexual Misconduct Coverage (optional coverage) from page 9 $_____(b)
❍ Defense Reimbursement Only or ❍ Liability Coverage

Step 3: Total (add lines a+b) $_____(c)

Step 4: Round the total in Step 3 (c) to the nearest dollar ($0.50 and above = round up; $0.49 and below = round down) $_____(d)

Step 5: Calculate Surplus Lines/Stamping/Transaction Fees – this is based on the Named Insured's state from page 5

NOTE: If your state is not specifically listed, use the last column labeled "All Other States". All states must calculate a surplus lines/stamping/transaction fee.

Insured's State	HI	IL	MI	MT	NV	NY	OK	UT	WY	All Other States
Surplus Line Tax	.0468	.035	.025	.0275	.035	.036	.06	.0425	.03	.025
Stamping/Transaction Fee	N/A	.0004	N/A	N/A	.004	.0015	.00175	.0018	.00175	N/A
FINAL STATE RATE	**.0468**	**.0354**	**.025**	**.0275**	**.039**	**.0375**	**.06175**	**.0443**	**.03175**	**.025**

Premium from Step 4 -$_____(d) x **Final State Rate** from chart above $_____ = $_____(e)

Step 6: Cost Total (add lines d + e) $_____(f)

RPG Fee $ 20.00 (g)

Step 7: Final Cost (add lines f + g) $_____

Step 8: Select Payment Option

NOTE: This program is 100% fully earned at inception. Premium Finance payments cannot be accepted, unless the premium finance company agrees to the 100% fully earned policy.

❍ ACH – this option is only available for purchases made 15 days or more prior to the effective date
Proceed to https://res.epaypolicy.com to complete the ACH payment

❍ Mail in Check – make check payable to Academic HealthPlans, Inc.

Academic HealthPlans, Inc.
PO Box 736073
Chicago, IL 60673-6073

❍ Credit Card - please note there will be a 3.5% fee added for credit card transactions
Proceed to https://res.epaypolicy.com to complete the credit card payment.

Step 9: Applicable to New York and Wyoming applicants only.

New York Applicant - please see instructions on page 16 on how to complete page 17.

Wyoming Applicant - please see instructions on page 16 on how to complete page 18.

NEW YORK and WYOMING APPLICANTS

Instructions for completing pages 17 and 18

NEW YORK APPLICANTS:

Please complete page 17 and return to us. Coverage cannot be bound without receipt of this completed form.

Step 1: Complete the Named Insured Box. Use the same name and address as completed on page 5.

Step 2: Complete the Named Insured Line. Use the same name as shown above in the Named Insured Box.

Step 3 Enter your policy premium. This can be found on page 15, line d.

Step 4 Enter your State Surplus Lines Tax.

To calculate, enter the amount from page 15, line d below and take that premium times the rate shown. Enter this amount on the Excess Line Tax line.

$.036 x $_____ = $_____

Amount from line d, page 15

Step 5: Enter your State Stamping Fee.

To calculate, enter the amount from page 15, line d below and take that premium times the rate shown. Enter this amount on the Stamping Fee line.

$.0015 x $_____ = $_____

Amount from line d, page 15

Step 6: Enter your Total Policy Cost. Add together the amounts from steps 3 – 5 and enter the total on this line.

Step 7: Sign the form. Please note, this needs to be signed by the insured (contact name on the application). A broker cannot sign this form.

WYOMING APPLICANTS:

Please complete page 18 and return to us. Coverage cannot be bound without receipt of this completed form.

Step 1: Complete the Named Insured Line. Use the same name as completed on page 5.

Step 2: Complete the Named Insured Line. Use the same name as shown above.

Step 3: Sign, date and provide your title. Please note, this needs to be signed by the insured (contact name on the application). A broker cannot sign this form.

K&K INSURANCE AGENCY
1690 Broadway, Bldg 19, Ste 110
Fort Wayne, IN 46802

NOTICE OF EXCESS LINE PLACEMENT

Named Insured: _____
Mailing Address: _____
City:_____**State:** _____ **Zip:** _____

Consistent with the requirements of the New York Insurance Law and Regulation 41 _____
(Named Insured)
is hereby advised that all or a portion of the required coverages have been placed by K&K INSURANCE AGENCY with insurers not authorized to do an insurance business in New York and which are not subject to supervision by this State. Placements with unauthorized insurers can only be made under one of the following circumstances:

a) A diligent effort was first made to place the required insurance with companies authorized in New York to write coverages of the kind requested; or
b) NO diligent effort was required because i) the coverage qualifies as an "Export List" risk, or ii) the insured qualifies as an "Exempt Commercial Purchaser".

Policies issued by such unauthorized insurers may not be subject to all of the regulations of the Superintendent of Financial Services pertaining to policy forms. In the event of insolvency of the unauthorized insurers, losses will not be covered by any New York State security fund.

TOTAL COST FORM (NON TAX ALLOCATED PREMIUM TRANSACTION)

In consideration of your placing my insurance as described in the policy referenced below, I agree to pay the total cost below which includes all premiums, inspection charges(1) and a service fee that includes taxes, stamping fees, and (if indicated) a fee(1) for compensation in addition to commissions received, and other expenses(1).

I further understand and agree that all fees, inspection charges and other expenses denoted by(1) are fully earned from the inception date of the policy and are non-refundable regardless of whether said policy is cancelled. Any policy changes which generate additional premium are subject to additional tax and stamping fee charges.

RE: Policy No. TBD Insurer AIG SPECIALTY INSURANCE COMPANY

Policy Premium		$_____
Insurer Imposed Charges		
Taxable Policy Fees	(1)	$0.00
Taxable Inspection Fee	(1)	$0.00
Service Fee Charges		
Excess Line Tax (3.60%)		$_____
Stamping Fee (0.15%)		$_____
Broker Fee	(1)	$0.00
Inspection Fee	(1)	$0.00
Other Expenses (specify)	(1)	$0.00
	Total Policy Cost	$_____

_____
(Signature of Insured)
(1) = Fully earned

NYSD Form: NELP/2011

Wyoming Insurance Department

Surplus Lines Notice to Insured

106 East 6th Avenue
Cheyenne, WY 820002
(307) 777-7401

Named Insured:_____

Surplus Lines Insurance Company: AIG Specialty Insurance Company

Policy Effective Dates: TBD Expiration Date: TBD

I, _____, hereby affirm that, prior to placement of the above-referenced insurance
(Named Insured)
coverage with a surplus lines insurer I have been advised that:

(i) The insurer with which the surplus lines broker places the insurance is not license by this state and is not subject to its supervision; and

(ii) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the Wyoming Insurance Guaranty Association.

I further understand that the policy forms, conditions, premium and deductibles ussed by surplus lines insurances may be different from those found in policies used by admitted insurance companies.

_____ _____

Signature of Named Insured Date

_____

Title

As required by Wyo. Stat. § 26-11-109(b), a copy of this form shall be retained by the surplus lines broker.