Coaches' Choice

SPORTS INSTRUCTOR

Insurance Program and Enrollment Form

This brochure is valid for effective dates from 3/1/26 through 2/28/27

PROGRAM DESCRIPTION

This insurance program has been specifically designed to meet the unique needs of a U.S.-based sports instructor directly supervising an individual or a group engaged in sports-related skills.

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

This program does not provide coverage for the operation, ownership, or maintenance of a fitness, sports, or dance facility. For information regarding coverage for a facility, please call us.

INELIGIBLE OPERATIONS

Operations not eligible for this program include, but are not limited to the following:

- Certified athletic trainers
- Coaching of organized competitive athletic teams
- Instructors under the age of 18
- Instructor's employment as an exempt or a non-exempt employee of a school, university, or college
- Instruction of the following:
  - -Boxing
  - -Canoeing
  - -Cycling
  - -Diving
  - -Equestrian
  - -Highland games
  - -Kayaking
  - -Lifeguarding
  - -Martial arts*
  - -Rowing
  - -Scuba diving
  - -Skiing
  - -Surfing
- Programs specifically designed for health disorders/ diseases (unless reported to and approved by us)

*For Martial Arts Instructors, please contact us or visit us online for more information.

For information or applications for sports facilities and/or teams, leagues, and associations, please visit our website or contact us.

ELIGIBLE OPERATIONS

A U.S.-based instructor age 18 or older conducting private or group instruction in any of the following sports is eligible to enroll in this program:

- Baseball
- Basketball
- Baton twirling
- Bowling
- Cheerleading
- Cross country
- Dance*
- Fencing
- Figure skating
- Football
- Golf
- Gymnastics (only eligible for Option 1)
- Hockey
- Lacrosse
- Pickleball
- Racquetball
- Road running
- Soccer/Futsal
- Softball
- Squash
- Swimming
- Table tennis
- Tennis
- Track and field (javelin/ hammer excl)
- Tumbling (floor only, no gymnastic apparatus)
- Volleyball
- Wrestling

*For instruction of dance only, please contact us or visit online.

EASY WAYS TO ENROLL FOR COVERAGE

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

OR

Submit this enrollment form, with payment, to us.

FAX 1-914-754-5617

MAIL Academic HealthPlans, Inc.
16201 West 95th Street, Ste. 210
Lenexa, KS 66219

FOR SERVICE REQUESTS ONLY

QUESTIONS Call 1-**914-754-5617**

E-MAIL
recsportsandmore@recsportsandmore.ahpcare.com

This brochure is for illustrative purposes only and is not a contract of insurance. You must refer to the actual policy for complete information regarding coverage terms, conditions, and exclusions as they may change from one coverage period to the next. You may request a copy of the full policy by submitting a written request to us.

EXCLUSIONS

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

- Sexual abuse or sexual molestation
- Amusement devices (e.g.: rides, slides, inflatables, bungees, climbing walls, dunk tanks)
- Communicable disease
- Cryogenic chambers/therapy
- Cycling (other than stationary)
- Employment-related practices
- Instruction/activity being held on or in open water (e.g.: lakes, ponds, ocean)
- Medical, therapy, or health care services
- Operation, ownership, or management of a commercial sports facility
- Perfluoroalkyl and polyfluoroalkyl substances (PFAS)
- Physicals/stress testing
- Physical therapy, massage, or salon services
- Sale or distribution of herbal, medicinal, and/or nutritional products
- Those operations listed as ineligible

COVERAGES AND LIMITS

Coverages	Option 1	Option 2	Option 3	Option 4	Option 5
Commercial General Liability (CGL)	**Limits**	**Limits**	**Limits**	**Limits**	**Limits**
Each Occurrence Limit	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000	$ 5,000,000
General Aggregate Limit (Other than Products-completed Operations)	$ 5,000,000	$ 5,000,000	$ 5,000,000	$ 5,000,000	$ 5,000,000
Products-completed Operations Aggregate	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000	$ 5,000,000
Personal and Advertising Injury Limit	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000	$ 5,000,000
Legal Liability to Participants Limit	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000	$ 5,000,000
Professional Liability Limit	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000	$ 5,000,000
Damage to Premises Rented to You Limit (Fire Legal Liability)	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 1,000,000
Medical Expense Limit (other than participants)	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000
Program A - Sports instruction conducted at locations that are NOT owned or operated by the instructor					
1 year premium	$ 352.00	$ 528.00	$ 778.00	$ 1,028.00	$ 1,278.00
2 years premium	$ 634.00	$ 951.00	Not Available	Not Available	Not Available
Program B - Includes Program A locations and/or instruction conducted at the instructor's home or residence					
1 year premium	$ 440.00	$ 660.00	$ 910.00	$ 1,160.00	$ 1,410.00
2 years premium	$ 793.00	$ 1,190.00	Not Available	Not Available	Not Available

Coverage provided under this program includes:

Commercial General Liability with Broadening Endorsement – Coverage that protects the insured against liability claims for bodily injury and property damage arising out of premises, operations, products-completed operations, and personal and advertising injury.

Legal Liability to Participants – Coverage that offers protection against bodily injury liability claims brought by persons participating in sports activities under the direction of the insured.

Professional Liability – Provides protection against wrongful acts (negligent act, negligent error, negligent omission, or negligent breach of duty in the discharge of covered activities or operations) that occur under the operations of the insured.

FREQUENTLY ASKED QUESTIONS

1. **Can I apply for coverage over the phone?**
   Unfortunately, we are not able to accept your enrollment information over the phone at this time. Coverage may be purchased online, or you can complete an enrollment form and submit it by fax or mail.

2. **What is a general aggregate?**
   The General Aggregate is the maximum amount the insurance company will pay for all covered claims during a single policy period. Once the aggregate limit has been exhausted, no additional payments will be made for covered losses during that policy period.

3. **What are certificate requests? How do I complete this section on the enrollment form?**
   A member certificate is a document prepared by us providing you evidence of insurance. You will automatically receive a member certificate providing proof of coverage once coverage is bound. You only need to complete the certificate request section if you have been asked to provide another certificate, to an entity such as the facility where you work.

4. **I have been asked by the facility that I instruct at to add them as an "additional insured" to my policy. What does this mean and how do I do that?**
   An additional insured is a person or organization not automatically included as an insured under an insurance policy, but who is included or added as an insured under the policy at the request of the named insured. By providing an entity additional insured status, it now is entitled to defense and indemnity (if policy limits have not been exhausted) under your policy with no responsibility for premium payments.

   You can add an entity as an additional insured under the certificate request section of the enrollment form. Please provide their complete name, address, and relationship to you. All requests must be made in writing.

5. **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., 16201 West 95th Street, Ste. 210, Lenexa, KS 66219.

6. **Do I have coverage for virtual training?**
   Coverage extends to incidental virtual training provided by you (the Named Insured) to your clients. The policy is intended to provide bodily injury coverage for training made available only to your clients through a private platform, such as a password-protected website or a closed Facebook group. Coverage does not extend to training material that is accessible to the general public.

   Reasonable precautions should be taken when assessing potential new clients/members online, including, but not limited to, health assessments, waivers and release forms, and interviews prior to instruction or training. We encourage you to consult with an attorney to consider waiver and release agreements that are specifically tailored to virtual training activities.

   Virtual training/instruction does not include any training or instruction that involves gymnastic apparatuses, tumbling, stunting (including pyramids), or in-water activities. We do not provide coverage for cyber liability. Therefore, if you collect payments or personal information online and that information is compromised, there would be no coverage under the General Liability policy.

Coaches' Choice Enrollment Form - Sports Instructor Insurance

Valid for effective dates from 3/1/26 through 2/28/27

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 potentially 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. 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 4 - 10)**
   ***New York and Wyoming applicants must also submit page 12 or 13**

NOTE: Coverage is not available for Alaska and Rhode Island applicants.

GENERAL INFORMATION

Instructor's name (as it should appear on the policy): _____
First name Last name

Doing business as (DBA): _____
(Additional name(s) under which the named insured operates. Note, coverage only applies to the individual and not to the business.)

Mailing address: _____
NY applicants must provide a street address. P.O. Boxes cannot be accepted.

City: _____ State: _____ Zip: _____

Insured phone: (_____) _____ Insured cell: (_____) _____

Insured e-mail: _____ Website: _____

(By listing an email address, you are giving us permission to contact you by email about your policy. Refer to page 7 for Consent for Electronic Transactions.)

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. Type of instructor (Check all that apply - If you don't see your sport listed, please contact us.)

❍ Baseball	❍ Cross country	❍ Gymnastics (Option 1 only)	❍ Road running	❍ Tennis
❍ Basketball	❍ Dance	❍ Hockey	❍ Soccer/Futsal	❍ Track and field (javelin/hammer excl)
❍ Baton twirling	❍ Fencing	❍ Lacrosse	❍ Softball	❍ Tumbling (floor only)
❍ Bowling	❍ Figure skating	❍ Pickleball	❍ Squash	❍ Volleyball
❍ Cheerleading	❍ Football	❍ Racquetball	❍ Swimming	❍ Wrestling
	❍ Golf		❍ Table tennis	

❍ Other: _____

2. Are you age 18 or older? ❍ Yes ❍ No
3. Do you instruct at your home/residence premises? ❍ Yes ❍ No
4. Do you own/operate your own facility and/or have employees/volunteers? ❍ Yes ❍ No

   If yes, this program only provides coverage for your operations as an instructor. It does not extend to your employees or anyone performing instruction or training on your behalf, nor does it apply to the operation of a facility.

Coverage is not provided for an instructor's employment as an exempt or non-exempt employee of a school, university, or college; for the coaching of organized competitive athletic teams; for activities of a certified athletic trainer; for programs designed for health disorders/diseases; and for instructors under the age of 18.

COST CALCULATION

Please check the appropriate program and option.
NOTE: Only Option 1 is available for gymnastic instructors.

❍ **Program A - Sports instruction conducted at locations that are NOT owned or operated by the instructor**

Options	Limit of Liability (CGL)	1 – Year Premium	2 - Years Premium
Option 1	$ 1,000,000	❍ $ 352.00	❍ $ 634.00
Option 2	$ 2,000,000	❍ $ 528.00	❍ $ 951.00
Option 3	$ 3,000,000	❍ $ 778.00	Not Available
Option 4	$ 4,000,000	❍ $1,028.00	Not Available
Option 5	$ 5,000,000	❍ $1,278.00	Not Available

❍ **Program B - Includes Program A locations and/or instruction conducted at the instructor's home or residence**

Options	Limit of Liability (CGL)	1 – Year Premium	2 - Years Premium
Option 1	$ 1,000,000	❍ $ 440.00	❍ $ 793.00
Option 2	$ 2,000,000	❍ $ 660.00	❍ $1,190.00
Option 3	$ 3,000,000	❍ $ 910.00	Not Available
Option 4	$ 4,000,000	❍ $1,160.00	Not Available
Option 5	$ 5,000,000	❍ $1,410.00	Not Available

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. 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.

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

2. 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.

3. Certificate holder/additional insured name: _____
Mailing address: _____
City: _____ State: _____ Zip: _____

4. 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 ❍ Cancellation - _____ days
❍ 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 incomplete or inaccurate names 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; Asbestos and silicosis; Cannabis; Certain computer-related losses; Commercial General Liability standard exclusions (CG0001 04/13 edition); Communicable disease; Cryogenic chambers/therapy; Cycling (other than stationary); Employment-related practices; ERISA; Fireworks; Fungus; Instruction/activity being held on or in open water; Lead; Medical, therapy, or health care services; Nuclear energy; Operation, ownership, or management of a commercial sports facility; Perfluoroalkyl and polyfluoroalkyl substances (PFAS); Physicals/stress testing; Physical therapy, massage, or salon services; Radioactive matter; Sale or distribution of medicinal, herbal, and/or nutritional products; Specified recreational vehicles and activities: Aircraft/hot air balloon; Airport; Amusement devices (The ownership, operation, maintenance or use of any amusement device. Amusement device means: 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; Concerts; 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; Total pollution; Those operations listed as ineligible: Certified athletic trainers; Coaching on behalf of a college, school, or any other organized competitive athletic team; Instruction of the following sports: Boxing, Canoeing, Cycling, Diving, Equestrian; Highland games; Javelin and hammer; Kayaking, Lifeguarding, Martial arts, Rowing, Scuba diving, Skiing, Surfing; Instructors under the age of 18; Instructor's employment as an exempt or non-exempt employee of a school, university, or college; Programs specifically designed for health disorders/diseases.

AGENT INFORMATION

ATTENTION AGENTS

Agents, you must complete the warranty section below. Enrollments cannot be accepted unless this section is completed.

Agency name:_____ Agent/contact name: _____

Agency complete mailing address: _____

Address City State Zip

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

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

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

By signing this proposal or application, I represent and warrant I have authority to sign on behalf of the producer and producer represents and warrants it shall not solicit, sell or bind any product unless it maintains, and will maintain, all individual, corporate or agency licenses or permits required to conduct insurance business in the state coverage is being written and to receive commission. Failure to acquire or maintain required licenses can result in forfeiture of commission. I further represent and warrant that the producer currently maintains, and will maintain, errors and omissions insurance with a minimum limit of $1,000,000. If requested, evidence of coverage or licensing will be provided for of all the above-mentioned items.

Agent signature: _____ **Date:** _____

COSTS ARE 100% NON-REFUNDABLE/NON-TRANSFERABLE 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 IS RECEIVED BY THE COMPANY OR THEIR REPRESENTATIVE.

CANCELLATIONS/CHANGES CAN ONLY BE MADE BY THE NAMED INSURED.

Academic HealthPlans, Inc. • 16201 West 95th Street, Ste. 210, Lenexa, KS 66219 • 1-914-754-5617
E-mail = recsportsandmore@recsportsandmore.ahpcare.com • Fax 1-914-754-5617
www.mycare26.com/specialty-programs
CA # 0H64806, TX # 1554208, FL # L074590

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SURPLUS LINES DISCLOSURE

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)

CONSENT FOR ELECTRONIC TRANSACTIONS

PLEASE READ AND COMPLETE THE BELOW
if you do not wish to receive documents via email and prefer another method of 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 1-914-754-5617 or mailing us at Academic HealthPlans, Inc., 16201 West 95th Street, Ste. 210, Lenexa, KS 66219. 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., 16201 West 95th Street, Ste. 210, Lenexa, KS 66219. 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.

PLEASE READ AND SIGN

Warranty 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.

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-transferable once coverage begins.

Applicant name (from page 4): _____

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. I agree that my electronic signature is the legally binding equivalent to my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.

❍ **Yes** ❍ **No**

Printed name: _____ **Title:** _____

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

FINAL PAYMENT CALCULATION AND PAYMENT OPTIONS

Step 1: Applicant name from page 4: _____

Step 2: Enter program premium:

Liability premium from page 5. $_____(a)

Step 3: Round the total in Step 2 (a) to the nearest dollar: ($0.50 and above = round up; $0.49 and below = round down) $_____(b)

Step 4: Calculate surplus lines/stamping/transaction fees – this is based on the Named Insured's state from page 4.

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 3 -$_____(b) x **Final State Rate** from chart above $_____ = $_____(c)

Step 5: Liability premium (add lines b + c): $_____(d)

Risk Purchasing Group Administration Fee: $ 20.00 (e)

Step 6: TOTAL COST (add lines d + e): $_____

Step 7: 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. Note: A $3 fee will apply.

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

Academic HealthPlans, Inc.
16201 West 95th Street, Ste. 210
Lenexa, KS 66219

❍ 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 8: Applicable to New York and Wyoming applicants only.

New York applicants - please see instructions on page 11 on how to complete page 12.

Wyoming applicants - please see instructions on page 11 on how to complete page 13.

NEW YORK and WYOMING APPLICANTS

Instructions for completing pages 12 and 13

NEW YORK APPLICANTS:

Please complete page 12 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 4.

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 10, line b.

Step 4 Enter your State Surplus Lines Tax line.

To calculate, enter the amount from page 10, line b below and take that premium times the rate shown. Enter this amount on the Excess Line Tax line.

$.036 x $_____ = $_____

Amount from line b, page 10

Step 5: Enter your State Stamping Fee line.

To calculate, enter the amount from page 10, line b below and take that premium times the rate shown. Enter this amount on the line Stamping Fee line.

$.0015 x $_____ = $_____

Amount from line b, page 10

Step 6: Enter your Total 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 13 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 4.

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.