Coaches' Choice

AMATEUR SPORTS ADULT SOCCER TEAMS, LEAGUES, CLUBS AND ASSOCIATIONS

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 is designed for U.S.-based teams, leagues, club, and associations conducting amateur adult soccer sports activities, where at least 80% of the players within the organization are age 18 and over, with NO players under the age of 16.

Coverage provided includes important liability protection for the organization, including its employees and volunteers, for liability claims arising out of its operations. Covered operations consist of scheduled, sanctioned, approved, organized, and supervised amateur soccer practices, try-outs, clinics, games, playoffs, and tournaments in which you participate or that you host. Coverage is also provided for your registrations, meetings, concession stand operations, parades in which you participate, picnics, award banquets, and ceremonies, and incidental fund-raising activities involving the sale of products, coupons, raffle tickets, and services, such as car washes, bake sales, and coin drops related to your amateur soccer operations.

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

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 the appropriate premium paid)
- All operations listed as ineligible
- Amusement devices (e.g.: rides, slides, inflatables, bungees, climbing devices)
- Bodily injury to participants while in a hired or non-owned auto, or use of multi-passenger vehicles
- Collegiate summer teams/leagues/association
- Communicable disease
- Concerts, carnivals, or festivals
- Cryogenic chambers/therapy
- Dunk tanks
- Events where alcoholic beverages are furnished or served
- Intercollegiate and Interscholastic teams, leagues, and associations
- Operation, ownership, or management of any athletic facility or field, other than while being used for covered activities
- Participants under the age of 16
- Room and board liability
- 24-hour premises liability (unless optional coverage for sports fields is purchased)

ELIGILBILITY REQUIREMENTS

1) At least 80% of the organization's participants must be 18 years of age or older, with NO players under the age of 16.
2) ALL "players" and/or parents/guardians must sign a release/waiver.
3) A roster of ALL participants must be submitted and on file with the company. Please include the age (not birthdate) beside their name on the roster for any participants under the age of 18.
4) If you do not have a complete roster at the time of binding, the only option available to purchase is option 3.

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 1-913-754-5617

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

FOR SERVICE REQUESTS ONLY

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

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 term to the next. You may request a copy of the full policy by submitting a written request us.

COVERAGES AND LIMITS

* Please contact us if higher limits are needed. *

Coverage	Option 1	Option 2	Option 3
Commercial General Liability (CGL) Each Occurrence Limit	$ 1,000,000	$ 1,000,000	$ 1,000,000
General Aggregate Limit (other than Products-completed Operations)	$ 5,000,000	$ 5,000,000	$ 5,000,000
Products-completed Operations Aggregate	$ 1,000,000	$ 1,000,000	$ 1,000,000
Personal and Advertising Injury Limit	$ 1,000,000	$ 1,000,000	$ 1,000,000
Damage to Premises Rented to You Limit (Fire Legal Liability)	$ 1,000,000	$ 1,000,000	$ 1,000,000
Medical Expense Limit (other than members/participants)	$ 5,000	$ 5,000	$ 5,000
Hired Auto Liability Limit	$ 1,000,000	$ 1,000,000	$ 1,000,000
Non-Owned Auto Liability Limit	$ 1,000,000	$ 1,000,000	$ 1,000,000
Legal Liability to Participants Limit (LLP)	$ 1,000,000	$ 500,000	Excluded
Professional Liabilit Limit	$ 1,000,000	$ 1,000,000	$ 1,000,000
Medical Payments for Participants - excess (MPP) - $1,000 corridor deductible	$ 10,000	Excluded	Excluded
Neurodegenerative Injury Limit/ Aggregate Limit	$ 1,000,000 / $ 1,000,000	$ 500,000 / $ 500,000	Excluded
Neurodegenerative Injury Supplementary Payments Limit/Aggregate Limit	$ 1,000,000 / $ 1,000,000	$ 500,000 / $ 500,000	Excluded
Rates:			
Per Player Rate	$ 35.91	$ 7.42	$ 5.18
Minimum Premiums	$ 800.00	$ 400.00	$ 300.00

Subject to the option purchased, coverage provided under this program may include:

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-completed operations, and personal and advertising injury.

Legal Liability to Participants (OPTIONAL) – coverage which offers protection against bodily injury liability claims brought by persons participating in covered activities.
A “player” = a soccer player, whether or not registered with the Named Insured, while participating in “covered activities”.

Medical Payments for Participants (OPTIONAL) – coverage which pays the medical and dental expenses incurred by a member/ participant as a result of an accidental injury sustained while participating in the tournament or event you are organizing. This 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 $1,000 corridor deductible applies to each claim, and the benefit period is two years from the date of the accident.

Professional Liability – provides protection against claims that arise out of the rendering or failure to render instruction, demonstration, direction, and/or advice relating to the sports activity.

Hired Auto and Non-Owned Auto Liability - coverage which protects the insured against liability claims arising out 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 bodily injury to participants while in a hired or non-owned auto, 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.

Limited Neurodegenerative Injury (“Neuro”) - 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.

OPTIONAL COVERAGES

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: Sexual Misconduct Liability - $250,000 each "Insured Event", 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 Aggregate Limit of Insurance.

Option 2: Abuse, Molestation, Harassment, or Sexual Conduct Defense Costs Reimbursement - $100,000 per claim, not to exceed $100,000 in the aggregate, 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 event with our Adult Soccer Teams, Leagues, Clubs and Assocations insurance program.
3. Only one option may be purchased.

	Coverage Options	Limit Option (must match the same option selected for CGL coverage)	Rates
❍	Sexual Misconduct Liability (defense expenses included in the limit)	**Option 1**	$1.30 (per player)
		Option 2	$1.24 (per player)
		Option 3	$1.04 (per player)
❍	Abuse, Molestation, Harassment, or Sexual Conduct Defense Costs Reimbursement	**Option 1**	$100 Flat Rate
		Option 2	$100 Flat Rate
		Option 3	$100 Flat Rate

Equipment and Contents Coverage (Inland Marine)

Our inland marine policy is designed to provide coverage for direct loss or damage to your sports equipment, field maintenance equipment, concession stand equipment (excluding products) and small portable storage units, scoreboards, dugouts, bleachers, and other appurtenant structures under 500 square feet and/or under 20 feet in height that you own. **Coverage applies to property you own, and property in your care, custody, or control (such as items you are renting or responsible for under contract). You must insure the full replacement cost of all your equipment and contents to avoid a coinsurance penalty at the time of loss.** If you add additional equipment or contents to your inventory, please contact us to amend your insured value.

Coverage conditions:

1. Coverage is not available on a stand-alone basis. You must have Commercial General Liability coverage for your team, league, or association with our Amateur Sports Teams, Leagues, and Associations RPG insurance program.
2. Coverage does not extend to appurtenant structures over 500 sq ft and 20 ft in height. In addition, coverage does not extend to irrigation systems or turf.
3. Coverage will be effective the day after we receive the proper completed enrollment form with premium and will expire on the expiration date of your Amateur Sports Teams, Leagues, and Associations RPG insurance program.

Total Value per Location	Rates	Deductible	Minimum Premium
$ 1 - $ 10,000	$ .03	$ 250	$ 100.00
$ 10,001 - $100,000	$ .026	$ 1,000	$ 100.00
$ 100,001 +	$ .026	$ 2,500	$ 100.00

Hosted Tournament Coverage - Only available with Options 1 and 2

Must be 3 days or less in duration, have 8 teams or fewer, have no more than 100 outside participants, and no more than 1000 spectators attending.

Hosted tournaments are those you organize and operate that include participants who are not members of your club or team. Coverage excludes non-rostered participants that participate in tournaments you host unless this optional coverage is purchased. The Named Insured and their rostered members are automatically covered for participation in tournaments conducted by others without purchasing this additional coverage. Please contact us for additional information on this optional coverage.

Premises Liability for Sports Fields Coverage

If you are a not-for-profit organization and you own, operate, or are responsible for a sports field(s) on a 24-hour basis and do not rent, donate, or lease the field(s) out to other organizations, this coverage provides you with premises liability for the field(s). The field(s) may only be for those sports and age groups for which you have purchased Commercial General Liability coverage for under the Amateur Sports Adult Soccer RPG insurance program. Please contact us for additional information on this optional coverage.

Directors' & Officers' Liability including Employment Practices Liability, for Not-for-Profit Organizations

This coverage provides important protection for not-for-profit organizations for claims arising out of alleged errors, omissions, or wrongful acts committed by its directors, officers, employees, or volunteers. It can respond to allegations of discrimination, wrongful dismissal, acts beyond granted authority, failure to deliver services, and wrongful employment practices. Please contact us for additional information on this optional coverage.

FREQUENTLY ASKED QUESTIONS

1. **Our organization has not had tryouts and we are not sure how many participants we will have. How should I report my number of participants?**
   You will need to report the maximum number of participants according to your projected rosters. You may add additional participants at any time. Please contact us if you need to increase your participant count. Refunds resulting from over-reporting of participants are not allowed.
2. **What information should the waiver contain? Will it stand up in court? Who should approve the waiver form and its content? Do we send in the signed waivers or keep them in our records database?**
   We have provided a sample waiver for your review on the following page. Final wording should be as directed by your attorney/legal counsel, but should observe the principles represented within the sample waiver. Minor participants should sign the waiver as well as the minor's parent or guardian. You should keep all signed waivers in case of a claim, at which time a copy of the signed waiver will be requested from the claims adjuster.
3. **What are your roster requirements?**
   A current and complete roster with names of all participants, and for those participants that are under age 18 also include their age (not birthdate). You must attach a complete roster with this enrollment. If your roster is not complete for the year, please submit last year's roster. You have up to 7 days to amend the names on the roster submitted.
   Additional players can be reported and added throughout the year as they play with your organization once any additional premium due is paid. It will be the responsibility of the applicant to keep rosters up to date and on file with the insurance company.
4. **What is a corridor deductible?**
   With a corridor deductible, the deductible amount is ALWAYS applied against the first bills paid by the medical payments for participants' coverage, no matter what has been paid by other insurance.
5. **Will we receive a policy after submitting 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

PARTICIPANT RELEASE OF LIABILITY AND REQUIREMENT:

A Waiver/Release Assumption of Risk form **MUST** be signed by **ALL** participants and the named insured is required to keep records of all signed waivers. Failure to comply with this condition is grounds for declination of a claim.

A **SAMPLE** Waiver/Release is provided below.

ASSUMPTION OF RISK AGREEMENT

READ BEFORE SIGNING

Organization Name/Named Insured (as shown on policy/certificate) : _____

Participant Name: _____

In consideration of being allowed to participate in any way in the program, related events and activities, I the undersigned, acknowledge, appreciate, and agree that:

1. The risk of injury from the activities involved in this program is significant, including the potential for permanent paralysis and death.

2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation.

3. I willingly agree to comply with terms and conditions for participation. If I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately.

4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE, INDEMNIFY, AND HOLD HARMLESS THE _____ , its officers, officials, agents and/or employees, other participants, sponsors, advertisers, and, if applicable, owners and lessors of premises used to conduct the event (RELEASEES), from any and all claims, demands, losses, and liability arising out of or related to any INJURY, DISABILITY OR DEATH I may suffer, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

SAMPLE

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

X_____ _____ _____

Participant's Signature Age Date

FOR PARENTS/GUARDIANS OF PARTICIPANT OF MINOR AGE

(UNDER AGE 18 AT TIME OF REGISTRATION)

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of all the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liability incidents to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES, to the fullest extent permitted by law.

X_____ _____ _____

Parent/Guardian Signature Date Emergency Phone Number(s)

NOTE: This is a SAMPLE WAIVER FORM only. Final wording should be as directed by the insured's counsel, but must observe the principles represented within the above. VG-77 (10/04)

Coaches' Choice

Enrollment Form Amateur Sports Adult Soccer Teams, Leagues, Clubs and Associations

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 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 6-17)
***New York and Wyoming applicants must also submit page 19 or 20**

NOTE: Please contact us prior to completing this enrollment form if limits above $1,000,000 are needed.

GENERAL INFORMATION

Full legal name of team, league, club, or association:_____

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/Individual ❍ Limited Liability Co. ❍ Corporation ❍ Partnership
❍ Other (describe): _____

Mailing address: _____

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

City: _____ State: _____ Zip:_____

Insured contact name: _____ 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 13 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 submit 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 enrollment form 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.

Academic HealthPlans, Inc. • 16201 West 95th Street, Ste. 210 Lenexa, KS 66219 • 1-913-754-5617
E-mail = recsportsandmore@recsportsandmore.ahpcare.com • Fax 1-913-754-5617
www.mycare26.com/specialty-programs
CA # 0H64806, TX # 1554208, FL # L074590

BUSINESS INFORMATION

1. Form of business:
   ❍ Not-for-profit organization ❍ For-profit organization

2. Type of organization:
   ❍ Individual team
   ❍ League or club - An entity organized to provide regulated competition for multiple teams participating in a specific sport.
   ❍ Association - An entity, usually not-for-profit, that exists to further a particular sport, and to protect the public interests of the participants in that sport. A fee is typically charged to become a member and formal rules and regulations are usually required and enforced.

3. Are you reporting all participants that are a part of your organization? ❍ Yes ❍ No
   If no, does your organization have teams and/or leagues that have coverage elsewhere? ❍ Yes ❍ No
   If you have coverage elsewhere, describe:_____
   _____

4. Do any of your teams include youth athletes (ages 16 -17)? ❍ Yes ❍ No
   If yes, at least 80% of your players must be 18 years of age or older to qualify for coverage.
   (No player under the age of 16 is allowed to participate. Allowing a player under the age of 16 may jeopardize coverage for the named insured and participants.)

5. Do you obtain a Waiver/Release Assumption of Risk form from ALL participants and keep records of all signed waivers in accordance with your state's record-keeping requirements? ❍ Yes ❍ No

6. Does the named insured own or have 24-hour responsibility for a facility or field? ❍ Yes ❍ No

7. Is any form of player compensation or prize money awarded for participation in your organization? ❍ Yes ❍ No

8. Are you a school, university, or college sanctioned sports team, club, or league? ❍ Yes ❍ No

9. Are you a municipality or a parks and recreation division? ❍ Yes ❍ No
   (This program ONLY provides coverage for your municipality or parks and recreation division with respect to those teams/leagues reported and approved.)

10. Are any of your activities held on private residential property? ❍ Yes ❍ No

11. Do you have concussion management protocols/guidelines that are consistently enforced and include communication (in written or electronic form) of education materials to participants, parents, and coaches about the nature and 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

12. 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 that sports liability waivers (informed consent) from parents and/or players are secured ❍ Yes ❍ No

Note: Some of the exposures/activities listed above may or may not be covered by this program, and any resulting claims could be denied. If you wish to cover any of these activities, please contact us to determine whether other coverage options are available.

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.

PROGRAM PREMIUM CALCULATION

Important Information

- Coverage is not available for Alaska and Rhode Island applicants.
- Premium is determined by applying the appropriate rate (see below) with the option selected.
- Attach a copy of your roster to this enrollment form. Your roster should only include the players' names and ages. DO NOT include their birthdates.
- You must submit all players' names prior to their participation for coverage to extend to them. You may report additional players throughout the year, and their coverage will begin the day after they are reported and the appropriate premium is paid.
- The number of players shown on the roster must match the number reported below.
- Without a submitted roster, Option 3 is the only coverage option available. Please note that Coverage Option 3 EXCLUDES Participant Legal Liability and Medical Payments for Participants coverage. Refer to page 2 for coverage descriptions and definitions of these participant-injury-related coverages.
  Once you receive your roster, please submit it and advise if you need to amend your coverage to another option. Changes can only be effective the day after receipt or on a future date.

Step 1: Do you have a complete roster? ❍ Yes ❍ No

If no, proceed to Step 2.

If yes, complete the questions below and then proceed to Step 3.

a) How many players do you have on your roster that are either age 16 or 17? _____

b) How many players do you have on your roster who are age 18 and over? _____

c) Add together lines a and b to get your total number of players. _____

Total Players

Step 2: Complete this step only if you do not have a roster at the time of binding and then proceed to Step 3.

a) How many teams do you expect to have? _____

b) How many players do you allow on a team? _____

c) Multiple line a with line b to get your total number of players. _____

Total Players

Step 3: Select your coverage option.

❍ Option 1	$1,000,000 $1,000,000 $ 10,000	Commercial General Liability Participant Legal Liability Medical Payments for Participants	Rate: $35.91 per player	Minimum Premium: $800.00
❍ Option 2	$1,000,000 $ 500,000 $ EXCLUDED	Commercial General Liability Participant Legal Liability Medical Payments for Participants	Rate: $7.42 per player	Minimum Premium: $400.00
❍ Option 3	$1,000,000 $EXCLUDED $EXCLUDED	Commercial General Liability Participant Legal Liability Medical Payments for Participants	Rate: $5.18 per player	Minimum Premium: $300.00

Step 4: Calculate your premium.

Total Players from Above	X	Rate from Above	=	Total Calculated Premium	Minimum Premium from Above
	X	$	=	$	$
Total Premium Due: If the total calculated premium is less than the minimum premium, the total premium due will be the minimum premium.					$

A copy of all player registrations MUST be maintained and reported, and must be available for us to review upon request. Failure to provide accurate player numbers/rosters could result in the denial of a claim.

OPTIONAL COVERAGES PREMIUM CALCULATION

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/Independent Contractors" means someone, including parent volunteers, who exerts control over or supervises participants.
2. Have any claims, allegations, convictions, 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 areas 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: _____

_____

_____

_____

_____

_____

See next page for SAM Calculation

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

6. Calculate premium:

Coverage Options	Limit Option (must match the same option selected for CGL coverage)	Rates
$250,000 Sexual Misconduct Liability (defense expenses included in the limit)	**Option 1**	$1.30 (per player)
	Option 2	$1.24 (per player)
	Option 3	$1.04 (per player)
$100,000 Abuse, Molestation, Harassment, or Sexual Conduct Defense Costs Reimbursement	**Option 1**	$100 Flat Rate
	Option 2	$100 Flat Rate
	Option 3	$100 Flat Rate

PREMIUM CALCULATION

Select your Coverage Option	Must Match the Same Limit Option as Selected on Page 8	Select the Rate from Above	X	Total Players from Page 8	=	Premium Total
❍ **$250,000 Sexual Misconduct Liability**	❍ Option 1 ❍ Option 2 ❍ Option 3	$	X	_____	=	$
	Minimum Premium					$ 150.00
	Total Premium Due: If the total calculated premium is less than the minimum premium, the total premium due will be the minimum premium.					$
❍ **$100,000 Abuse, Molestation, Harassment, or Sexual Conduct Defense Costs Reimbursements**						$ 100.00

OPTIONAL COVERAGES PREMIUM CALCULATION CONTINUED

Equipment and Contents Coverage (Inland Marine)

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

Step 1: Provide values below to determine your total replacement cost amount for ALL locations. **You must insure the full replacement cost of all your equipment and contents to avoid a coinsurance penalty at the time of loss. Fill in the values to determine your total replacement cost amount for ALL locations.**

Individually list any items with values over $5,000 — **Value**

_____ $_____

_____ $_____

_____ $_____

Provide values for categories below
(DO NOT include those values already shown above)

Sports equipment (e.g.: balls, uniforms, pads, helmets, netting) $_____

Field maintenance equipment (e.g.: lawn mowers, grooming equipment) $_____

Concession stand equipment, excluding products (e.g.: popcorn, hot dog and soda machines) $_____

Appurtenant structures – under 500 sq ft and 20 ft in height (e.g.: concession stands, dugouts, scoreboard, bathrooms) - please describe:_____ $_____

_____

Misc. equipment - please describe:_____ $_____

_____

Total replacement value for all location(s) (add all lines above) $_____

Step 2: Complete ONLY if your replacement cost value is over $100,000

1. Please describe the building type your equipment is stored in (e.g.: frame or fire resistive warehouse)

   _____

2. Do you have a security system in place? ❍ Yes ❍ No
   a. If yes, please describe:_____
3. Is any other operations, besides your own, conducted in the same facility in which you store your equipment, or is any equipment of others stored there? ❍ Yes ❍ No
   a. If yes, please describe:_____
4. Please attach a complete inventory list with values of each item.

Step 3: Calculate premium

If total calculated premium is less than the minimum premium, the total premium due is the minimum premium.

Equipment and Contents (Inland Marine) Premium

❍ **My total replacement value is between $1 - $10,000**
($250 deductible will apply)

$.03 x $_____ (Total Replacement Value) = $_____ $_____ (Equipment and Contents Premium ($100.00 minimum premium applies))

❍ **My total replacement value is over $10,000**
($1,000 deductible applies to values from $10,001 - $100,000 and a $2,500 deductible applies to values over $100,000)

$.026 x $_____ (Total Replacement Value) = $_____ $_____ (Equipment and Contents Premium ($100.00 minimum premium applies))

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

2. This certificate is for: ❍ General Liability Coverage

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.

If applicable:

6. For specific events: Date(s) of event/activity: _____/_____/_____ to _____/_____/_____

Hours of event/activity: _____ ❍ A.M. ❍ P.M. to _____ ❍ A.M. ❍ P.M.

Type of event/activity: _____ Name of event/activity: _____

Location of event/activity: _____

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. 24-hour premises liability (unless optional coverage for sports fields is purchased); 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; Athletic or sports participants in: all sports and age groups, other than amateur soccer for ages 16 and over; Babysitting/child care services; Bodily injury to participants while in a hired auto or non-owned auto; Cannabis; Carnivals/festivals; Certain computer-related losses; Collegiate summer teams/leagues/associations; Commercial General Liability standard exclusions (CG0001 04/13 edition); Communicable disease; Cryogenic chambers/therapy; Employment-related practices; ERISA; Events/Activities held outside of the U.S.; Events involving gambling (e.g.; bingo, casino nights, poker, Texas hold'em tournaments); Events where alcoholic beverages are furnished or served; Fireworks; Fungus; Intercollegiate and Interscholastic teams, leagues, and associations; Lead; Legal Liability to Participants (unless Option 1 or 2 is purchased); Medical Payments for Participants (unless Option 1 is purchased); Non-rostered participants at tournaments hosted by the enrolled member; Participants under the age of 16; Nuclear energy; Open water activities; Operation, 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); Professional or semi-professional team, leagues, events, competitions, practices, try-outs, clinics, games, playoffs and tournaments; Radioactive matter; Room and board liability; 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.); 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; Use of multi-passenger vehicles.

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)

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 1-913-754-5617 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.

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:** _____

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 business name (from page 6): _____

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

(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 6 _____

Step 2: Enter program premiums:

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

Sexual misconduct coverage (optional coverage) from page 10 $_____(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 6

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: Liability cost (add lines d + e) $_____(f)

Risk Purchasing Group Administration Fee $ 20.00 (g)

Step 7: Enter equipment and contents premium (optional coverage) from page 11. $_____(h)

Step 8: TOTAL COST (add lines f, g, + h) $_____

Step 9: Select payment option.

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

New York Applicant - Please see instructions on page 18 on how to complete page 19.

Wyoming Applicant - Please see instructions on page 18 on how to complete page 20.

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NEW YORK and WYOMING APPLICANTS

Instructions for completing pages 19 and 20

NEW YORK APPLICANTS:

Please complete page 19 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 6.

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 17, line d.

Step 4 Enter your State Surplus Lines Tax.

To calculate, enter the amount from page 17, 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 17

Step 5: Enter your State Stamping Fee.

To calculate, enter the amount from page 17, 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 17

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 20 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 6.

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.