Coaches' Choice

Youth Camp and Clinic Supplemental Request Form

For Adding Additional Camp and/or Clinic Session Dates
This supplemental is valid for effective dates from 3/1/25 through 2/28/26

Please retain a copy of this form for your records.

GENERAL INFORMATION

Named insured (as it appears on your Member Certificate):_____

Policy number (as it appears on your Member Certificate): _____

Mailing address: _____

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

City: _____ State: _____ Zip:_____

Contact name: _____ Phone: (_____) _____

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

E-mail: _____ Website: _____

EXPOSURE INFORMATION

Please note:

- You must submit this request form prior to the start of your camp and/or clinic along with payment. Coverage cannot be bound without the proper payment and completed and approved supplemental.
- You must provide the actual or maximum amount of expected campers. TBD numbers can not be accepted.
- Changes to numbers reported, must be reported in writing on or before the start of the camp and/or clinic session.
- Cancellations must be reported in writing on or before the start of the camp and/or clinic session.

1. Do any of your camps include any of the following sports? ❍ Yes ❍ No

If yes, please check those that apply and answer questions a. and b.

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

a. Do you have concussion management protocols/guidelines that are consistently enforced and includes communication (in written or electronic form) of education materials to participants, parents and coaches about the nature of risk of concussions including but not limited to information such as focusing on prevention and preparedness to keep athletes safe; understanding concussions and potential consequences of the injury; recognizing concussion symptoms and how to respond; and learning about steps for returning to play after suspected concussion? ❍ Yes ❍ No

b. If you suspect an athlete has a concussion, do you have an action plan that includes:

- Immediately removing the athlete from play or practice ❍ Yes ❍ No
- Keeping the athlete out of play or practice until they provide written clearance from a licensed physician ❍ Yes ❍ No
- Confirming sports liability waivers (informed consent) from parents and/or players are secured ❍ Yes ❍ No

Academic HealthPlans, Inc. • PO Box 81315, Cleveland, OH 44181 • 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

CAMP RATES

Use these rates to figure out your camp premiums on the next page

CLASS 1 RATES

Type of Camp Sessions	Option 1 $1,000,000 CGL & $25,000 Med Pay to Part.	Option 2 $2,000,000 CGL & $250,000 Med Pay to Part.	Option 3 $3,000,000 CGL & $250,000 Med Pay to Part.	Option 4 $4,000,000 CGL & $250,000 Med Pay to Part.	Option 5 $5,000,000 CGL & $ 250,000 Med Pay to Part.
Daily (no overnight sessions) • 2 consecutive days or less; OR • Multiple non-consecutive days	$1.45	$1.97	$2.16	$2.27	$2.35
Weekly (no overnight sessions) 3–7 consecutive days	$4.33	$5.99	$6.55	$6.89	$7.13
Overnight/Resident • 1–7 consecutive days NOTE: Adult-accompanied camps are not eligiblefor this option	$5.75	$7.95	$8.69	$9.13	$9.46

CLASS 2 RATES

Type of Camp Sessions	Option 1 $ 1,000,000 CGL & $25,000 Med Pay to Part.	Option 2 $2,000,000 CGL & $250,000 Med Pay to Part.	Option 3 $3,000,000 CGL & $250,000 Med Pay to Part.	Option 4 $4,000,000 CGL & $250,000 Med Pay to Part.	Option 5 $5,000,000CGL & $250,000 Med Pay to Part.
Daily (no overnight sessions) • 2 consecutive days or less; OR • Multiple non-consecutive days	$1.60	$2.20	$2.42	$2.55	$2.65
Weekly (no overnight sessions) 3–7 consecutive days	$4.78	$6.66	$7.34	$7.74	$8.04
Overnight/Resident • 1–7 consecutive days NOTE: Adult-accompanied camps are not eligiblefor this option	$6.34	$8.83	$9.72	$10.25	$10.65

Note: Class 2 rates include Limited Neurodegenerative Injury Coverage to Specified Players for Sports or Athletic Activities for those sports with this limitation. If you did not purchase this coverage, adjustments will be made at the time of binding.

SEXUAL MISCONDUCT LIABILITY RATES

(use only if you were approved and purchased this coverage at the time of your original binding)

Daily Rate	Weekly Rate	Overnight Resident Rate
$0.15	$0.45	$0.59

CAMP PREMIUM CALCULATIONS

IMPORTANT INFORMATION:

1. Please list each camp session individually. Do not combine a period of camp dates. Should you have more than 3, please provide additional copies of this page.
2. Coverage only applies to those camp sessions specifically reported and approved, before the camp starts.
3. The same limit option must be used for all camps.
4. If multiple sports are in a single camp, the highest sport class applies for that camp.

CAMP/SESSION #1

Name of camp: _____

Type of camp (list all the sport types and activities): _____

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

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

Camp location(s): _____

# of youth campers/participants (below age 19):_____ # of accompanying parent/guardian participants:_____

Does your current policy include Sexual Misconduct Liability Coverage? ❍ Yes ❍ No

If yes, make sure to include rating below. If no, do not include sexual misconduct rate

Coverage Option	Daily or Weekly Rate	+	Sexual Misconduct Rate (only if yes is checked above)	=	Total Rate	x	# of Days or Weeks	x	# of Campers (add youth + accompanying parent/guardian)	=	Premium
	$	+	$	=	$	x		x		=	$

CAMP/SESSION #2

Name of camp: _____

Type of camp (list all the sport types and activities): _____

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

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

Camp location(s): _____

# of youth campers/participants (below age 19):_____ # of accompanying parent/guardian participants:_____

Does your current policy include Sexual Misconduct Liability Coverage? ❍ Yes ❍ No

If yes, make sure to include rating below. If no, do not include sexual misconduct rate

Coverage Option	Daily or Weekly Rate	+	Sexual Misconduct Rate (only if yes is checked above)	=	Total Rate	x	# of Days or Weeks	x	# of Campers (add youth + accompanying parent/guardian)	=	Premium
	$	+	$	=	$	x		x		=	$

CAMP/SESSION #3

Name of camp: _____

Type of camp (list all the sport types and activities): _____

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

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

Camp location(s): _____

# of youth campers/participants (below age 19):_____ # of accompanying parent/guardian participants:_____

Does your current policy include Sexual Misconduct Liability Coverage? ❍ Yes ❍ No

If yes, make sure to include rating below. If no, do not include sexual misconduct rate

Coverage Option	Daily or Weekly Rate	+	Sexual Misconduct Rate (only if yes is checked above)	=	Total Rate	x	# of Days or Weeks	x	# of Campers (add youth + accompanying parent/guardian)	=	Premium
	$	+	$	=	$	x		x		=	$

CERTIFICATE REQUESTS

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.

CERTIFICATE REQUEST #1

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

1. Camp #:_____

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

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

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

❍ Other (please identify/explain): _____

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

4. Certificate holder/additional insured name: _____

_____

Mailing address: _____

City: _____ State: _____ Zip: _____

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

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

❍ Other (please explain): _____

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

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

CERTIFICATE REQUESTS

CERTIFICATE REQUEST #2

1. Camp #:_____

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

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

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

❍ Other (please identify/explain): _____

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

4. Certificate holder/additional insured name: _____

_____

Mailing address: _____

City: _____ State: _____ Zip: _____

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

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

❍ Other (please explain): _____

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

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

FINAL PAYMENT CALCULATION AND PAYMENT OPTIONS

Step 1: Applicant Business Name from page 1_____

Step 2: Enter Additional Camp Premiums:

Liability Premium (total premium from all additional camps) from page 3 $_____(a)

Step 3: Calculate Surplus Lines/Stamping/Transaction Fees – this is based on the Named Insured's state from page 1

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 2 -$_____(a) x **Final State Rate** from chart above $_____ = $_____(b)

Step 4: Cost Total (add lines a + b) $_____

PAYMENT OPTIONS

Submit completed supplemental and payment via one of the options below.

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

❍ ACH – this option is only available for purchases made 15 days or more prior to the effective date

Proceed to https://res.epaypolicy.com to complete the ACH payment

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

Academic HealthPlans, Inc.
PO Box 81315
Cleveland, OH 44181

❍ 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