



SPORTS APPLICATION SUPPLEMENT

1. Proposed First Named Insured & Other Named Insured(s):

2. Mailing Address Street City County State ZIP Code

3. Location Address Street City County State ZIP Code

4. Telephone: _____ Fax: _____
 Website: _____

5. Contact person/phone #: _____ Inspection: _____
 Accounting/Records: _____

6. Business Type: Individual Partnership Corporation LLC Trust
 Other (specify): _____

7. Operating as: For Profit Nonprofit Other:

8. Interest of Named Insured in premises: Owner General Lessee Tenant
 Other:

9. Part occupied by Named Insured: Entire Portion (%) Other (Lessor's Risk Only)

10. Date Business Established: _____
 If new venture, provide prior experience: _____

11. Effective Date Desired: From: _____ To: _____ Term Desired: _____

PREVIOUS INSURER & LOSS HISTORY – Attach separate sheet if necessary See Loss Runs Attached

Missouri Applicants: **DO NOT** answer this question.

Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?

No Yes - If Yes, give name of company, date, and reason:

Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the past 3 years:

Policy Dates	Carrier	Policy Number	Premium	Coverage	Check if Claims-Made	Description of Loss
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

BUSINESS INFORMATION

1. Location of camp, clinic, league or event (indicate all locations):

2. Is the camp accredited by A.C.A. (American Camp Association)? Yes No
3. Activity to be insured: Sports Camp Sports Clinic League
 Sports Camp (overnight) Sports Event Other:

4. Do you offer wilderness (outward bound) expeditions, military, survival or boot camps, or weight loss?
 Yes No If yes, provide details of operations:

COMPLETE ONLY THE SECTIONS THAT APPLY:

Athletic Participants Coverage

1. Do you have accident and health coverage on the campers? Yes No If yes, indicate:

Name of Insurer:

Policy Number:

Effective Dates:

2. Are waivers received on all individuals participating in the activity? Yes No

If yes, provide details:

Overnight Camps

1. Age of oldest counselor staying overnight with campers:

2. Age of youngest counselor:

3. Ratio of campers to counselors: (e.g. 5 counselors and 45 campers – 1:9)

4. Does at least one counselor stay overnight in each cabin or dormitory? Yes No

Attachments:

ACORD Application

Copy of Waiver

Marketing Brochures, Advertisements, etc.

FRAUD STATEMENTS

FLORIDA: 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.

LOUISIANA and MAINE: 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.

Refer to the Core Application for all Fraud Statements.

IMPORTANT NOTICE**DECLARATION**

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.

SIGNATURES

Applicant Signature

Title

Date

Producer Signature

Date

Producer Name and Address
