2017
Baseball / Softball Application

INDEX

Program Coverage Summary

General Liability* **(Coverage for fields, facilities, tournaments, etc…)**

*must purchase in order to include in policy

$2,000,000	General Aggregate	$1,000,000	Non Owned and Hired Auto[1]
$1,000,000	Per Occurrence	$1,000,000	Abuse and Molestation
$1,000,000	Personal and Advertising	$1,000,000	Participant Legal Liability[2]
$2,000,000	Products/Completed Operations	$- 0-	Medical Expense
$ 300,000	Damage to Rented Premises		(May be added if required by contract)

[1] **(Only applies to league officials on league business. Not valid for player transport or 15 passenger vans)**
[2] **(Requires Accident Medical Coverage)**

Accident Medical* **(Excess coverage for your participants)**

*must purchase in order to include in policy

$100,000	Accident Medical	**- OR-**	$250,000	Accident Medical
$ 10,000	Accidental Death & Dismemberment		$ 10,000	Accidental Death & Dismemberment
$ 2,000	Accidental Dental Benefit		$ 2,000	Accidental Dental Benefit

Broker Information

(If Not Applicable, Skip This Section)

Name of Agency / Brokerage:_____

Name of Contact / Agent:_____

Mailing Address of Agency / Brokerage:_____

City:_____ State:_____ Zip Code:_____

Phone:_____Fax:_____

Email:_____

Client Information

(Please Fill-in All Applicable Fields)

Organization/Association Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____Fax:_____

Email:_____

Presidents Name: _____

Individual Responsible For Insurance:_____

Add an Additional Contact Allowed to Request Information

Name:_____ Phone:_____ Email:_____

Name:_____ Phone:_____ Email:_____

Name:_____ Phone:_____ Email:_____

☐ **New Policy** (New to Gagliardi)

☐ **Renewal** (Renewing a policy)

☐ **Adding teams / coverages** (Adding to an existing policy)

Policy Underwriting Questions

Yes☐ No☐ Do you have a waiver in place that each participant must sign prior to play and would you be able to provide upon request?

Yes☐ No☐ If NO, do you agree to use the sample provided?

Yes☐ No☐ Do you have Risk Management Guidelines/Procedures in place?

Yes☐ No☐ If NO, do you agree to implement guidelines/procedures provided by our office?

Yes☐ No☐ Do your organization's risk procedures include some form of background check and/or other reviews of persons working with the team or league, including volunteers, coaches and officials?

Yes☐ No☐ If NO, do you agree to update your risk guidelines to include this procedure?

Yes☐ No☐ If NO, I understand that abuse & molestation coverage will be <u>excluded</u> from the policy. Initials _____

Program Rates

1. Please pick either Option #1 - **OR** - Option #2. (**If no Accident Medical coverage is desired, please leave blank**)
2. Please indicate # of teams in each age category, **all teams must have same limit and deductible**
3. Calculate Premium Due by multiplying "# of teams" by "deductible rate"
   (Rate varies by age/option/deductible)

General Liability - $2,000,000 Aggregate / $1,000,000 per Occurrence

Rate per Team		# of Teams						Premium Due
		10U	12U	16U	18U	21U		($49 x # of teams)
$49	x						=	$

Accident Medical Option #1 - $100,000 Limit ($3K Dental Limit Included)

Baseball Rates – ($100K Accident Medical Benefit)

Age Group	# of Teams		$50 Deductible	$100 Deductible	$250 Deductible		Premium Due
10 and Under		x	$34	$32	$25	=	$
12 and Under		x	$37	$34	$27	=	$
16 and Under		x	$68	$61	$50	=	$
18 and Under		x	$147	$119	$99	=	$
21 and Under		x	$235	$189	$158	=	$

Softball Rates – ($100K Accident Medical Benefit)

Age Group	# of Teams		$50 Deductible	$100 Deductible	$250 Deductible		Premium Due
12 and Under		x	$32	$28	$23	=	$
16 and Under		x	$65	$59	$50	=	$
21 and Under		x	$133	$121	$101	=	$

Accident Medical Option #2 - $250,000 Limit ($3K Dental Limit Included)

Baseball Rates – ($250K Accident Medical Benefit)

Age Group	# of Teams		$50 Deductible	$100 Deductible	$250 Deductible		Premium Due
10 and Under		x	$40	$37	$32	=	$
12 and Under		x	$44	$40	$33	=	$
16 and Under		x	$82	$74	$60	=	$
18 and Under		x	$176	$142	$119	=	$
21 and Under		x	$282	$227	$190	=	$

Softball Rates – ($250K Accident Medical Benefit)

Age Group	# of Teams		$50 Deductible	$100 Deductible	$250 Deductible		Premium Due
12 and Under		x	$34	$30	$28	=	$
16 and Under		x	$80	$71	$59	=	$
21 and Under		x	$161	$145	$121	=	$

Additional/Optional Coverages

Note: If elected, # of teams must match total # of teams from previous page

Excess Liability Limit (Increases your General Liability (Aggregate & Per Occurrence) by $4 million each)
**Requires General Liability*

Rate per Team		# of Teams		Premium Due
$13	x		=	$

Catastrophic Medical (Increases Accident Medical Benefit up to **$500,000**) **Requires Accident Medical*
Increase must match Accident Medical Benefit (Option #1 or Option #2). ***Please sign pg. 8**

Accident Medical Option	Deductible	Rate per Team		# of Teams		Premium Due
Option #1 ($100K)	$10,000	$18	x		=	$
Option #2 ($250K)	$25,000	$15	x		=	$

Playing Field Coverage (Must own fields or require 24 Hr. protection)
This coverage extends the liability policy to cover your organizations owned playing fields or fields which you are responsible for 24/7.

Yes☐ No☐ Are contractors utilized for maintenance and/or repair?

Yes☐ No☐ Do you allow outside entities to use your fields?

(If **Yes** to either of the above, certificate of insurance listing your organization as additional insured is required)

Rate		# of Fields (owned)		Premium Due
$165	x		=	$

Medical Expense Coverage
If you would like to purchase Medical Expense Coverage, please fill out this section:

Yes☐ No☐ Rate: $100 Premium | $5,000 limit

Directors & Officers Application

For multiple associations, make as many copies as required

Conference Name: _____

Association Name:_____

Address: _____

City:_____ State:_____ Zip Code: _____

Presidents Name:_____

Please indicate the total number of boards you wish to cover:

_____ board(s) | Premium: $345 | Deductible: $500
(#of board(s))

1.) Have any loss payments been made under any prior or current D&O or similar insurance?

Yes☐ No☐

2.) Has any league person given written notice under the provisions of any prior D&O liability or similar insurance of circumstances which might give cause for a claim against any insured person(s)?

Yes☐ No☐

3.) Are you aware of any circumstance which would afford valid grounds for any future claim(s) which would fall within the scope of this coverage?

Yes☐ No☐

Cyber Liability Endorsement – Yes ☐ No ☐
Premium: $100

Cyber Liability Details:

$100 K Regulatory Action Limit For:	**$100K Privacy Event Limit For:**
✓ Legal Fees incurred in response to a privacy loss ✓ Regulatory Action investigation	✓ Notifying individuals whose information was compromised
✓ Fines and penalties the organization is required to pay resulting from a Regulatory Action	✓ Legal fees to determine compliance requirements when information is compromised
✓ A fund to provide compensation to individuals as required by a Regulatory Action	✓ Credit Monitoring ✓ Identity Restoration Services ✓ The costs to engage a computer expert to identify how information was accessed

DECLARATION AND SIGNATURE: (Signature of Association President is Mandatory)

Although the signing of this application shall be the basis of the contract should a policy be issued, the company is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary. We must be notified in wring of any changes in Board of Directors.

Date: _____ Signature: _____

Fidelity Bond Application

A Fidelity Bond covers employee fraud or dishonesty, but will not cover cash/untraceable funds.

Each Fidelity Bond covers 5 Board Members on a single Board. If your Board has more than 5 members or your organization has more than one Board, you must purchase multiple Fidelity Bonds.

Please print as many copies of this page as needed to obtain coverage for all Boards and Members.

Please indicate the total number of each Fidelity Bonds you intend to purchase below:

_____ $35,000 Fidelity Bond | Premium $180 Deductible: $500
(#of bonds)

Have you sustained any employee dishonesty losses in the last six years? Yes ☐ No ☐

Board Association Name: _____

5 POSITIONS TO BE COVERED: (Job Title)	FULL NAME OF PERSON:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This bond covers only those 5 persons holding the "positions" designated while such person is engaged in activities sanctioned by the League. We must be notified in writing of any changes in covered positions / individuals.

Date: _____ Signature: _____

Sports Equipment Application

This application is for Sports Equipment Coverage.
Buildings and food products are NOT covered under this policy.

League/Team Name: _____

President: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Deductible $500 | Rate: $.0291 per every $1 of coverage subject to a $250 minimum premium.

Value of Equipment: _____ ($8,600 = Minimum Amount)

Premium $_____ ($250 Minimum Premium)

Total Premium = (.0291x value of equipment-or-$250, whichever is greater).

List all items valued over $1,000 with serial numbers and description.
*****Items valued at $1,000 that are not listed will not be covered*****

Attach additional sheet if necessary

Equipment	Serial Number	Equipment	Serial Number

Complete address where equipment is stored: _____

_____

1.) Is equipment stored in a locked facility with either a deadbolt or external locking device?
Yes☐ No☐ **- IF NO, ineligible for coverage.**

2.) Are there: Burglar Alarms☐ Fire Alarms☐ Automatic Sprinklers☐ None☐
(check all that apply)

Coverage is void if stored at a residence or in a vehicle

This form shows you understand you are buying into a "Master" not an "Individual" policy for your excess accident medical coverage. ***Please sign and date the required form, include with final submission.***

Starr Indemnity & Liability Participant Sports Insurance Trust
ACCIDENT MEDICAL PARTICIPATION AGREEMENT

The undersigned organization requests that it be approved as a Subscriber to the Starr Indemnity & Liability Participant Sports Insurance Trust. In making this request, the organization accepts and agrees to the appointment of Wilmington Savings Fund Society, FSB. The organization acknowledges that the purpose of the Trust is to make blanket accident insurance benefits available to eligible members. Insurance benefits are to be made available under blanket accident insurance policies as they become issued by Starr Indemnity & Liability Company to the Trustee. The undersigned organization agrees that it, and all participating eligible members, shall be bound by all the terms and conditions of each relevant blanket accident insurance policy, as they may from time to time be amended. The proposed participating Subscriber organization shall be notified by the Trustee (or its authorized representative) as to the acceptance or rejection of this request within 60 days of the date the request is made, or be given reason for further delay.

Name of Organization:_____

Authorized Signature: _____

Name & Title: _____

Date: _____

For information purposes only: Benefits for eligible persons of the Participant are provided under Master Policy BAP 660000

If you purchased the ***Catastrophic Medical*** *option (pg.4), please sign the below section as well.*
Otherwise it is not necessary to sign or turn this page in.

Starr Indemnity & Liability Participant Sports Insurance Trust
CATASTROPHIC MEDICAL PARTICIPATION AGREEMENT

The undersigned organization requests that it be approved as a Subscriber to the Starr Indemnity & Liability Participant Sports Insurance Trust. In making this request, the organization accepts and agrees to the appointment of Wilmington Savings Fund Society, FSB. The organization acknowledges that the purpose of the Trust is to make blanket accident insurance benefits available to eligible members. Insurance benefits are to be made available under blanket accident insurance policies as they become issued by Starr Indemnity & Liability Company to the Trustee. The undersigned organization agrees that it, and all participating eligible members, shall be bound by all the terms and conditions of each relevant blanket accident insurance policy, as they may from time to time be amended. The proposed participating Subscriber organization shall be notified by the Trustee (or its authorized representative) as to the acceptance or rejection of this request within 60 days of the date the request is made, or be given reason for further delay.

Name of Organization: _____

Authorized Signature: _____

Name & Title: _____

Date: _____
For information purposes only: Benefits for eligible persons of the Participant are provided under Master Policy BAP 670000

Additional Insured / Certificate Holder List

Complete address required for completion of certificate.
If Endorsement is required, please include copy of contract or insurance requirements.

☐ **Check here to duplicate certificates on file** (same as last year)
☐ **I am allowing others in my organization to access the account and request certificates.**

OR

☐ **I am the only one in my organization that can access account information and request certificates.**

Additional Insured (Full Name) Address City, State, Zip Relationship to Insured	Additional Insured (Full Name) Address City, State, Zip Relationship to Insured
Additional Insured (Full Name) Address City, State, Zip Relationship to Insured	Additional Insured (Full Name) Address City, State, Zip Relationship to Insured
Additional Insured (Full Name) Address City, State, Zip Relationship to Insured	Additional Insured (Full Name) Address City, State, Zip Relationship to Insured
Additional Insured (Full Name) Address City, State, Zip Relationship to Insured	Additional Insured (Full Name) Address City, State, Zip Relationship to Insured

Attach additional list of Additional Insured when necessary.
Or you may request online at www.gsportsinsurance.com – "Request a Certificate"

- Policy will begin upon receipt of application and premium, and will be valid for an annual term.
- No backdating will be allowed under any circumstances.
- To add teams at any time during the policy year please complete another application and submit to our office along with premium.
- Teams cannot be deleted or removed after policy has been bound and processed.

Policy Effective Date Requested: _____ TO _____
(annual terms)

ALL PREMIUMS ARE FULLY EARNED AT POLICY INCEPTION
No Refunds

Total Amount From Premium Due Columns: $_____

Agency Fee (non-refundable): $_____30_____

Expedite Fee (Optional 24hr Rush Delivery): ☐ ***$50 (optional)***
(Normal Processing is Approximately 5 Business Days)

Total Amount Due For Premiums and Fees: $ _____

Broker Name: _____ (*For Agents Only*)

Broker Code: _____ (*For Agents Only*)

☐ ← **New Brokers, check here to request Broker Kit (*For Agents Only*)**

I confirm that all information provided on this application is true to the best of my knowledge and understand that any inaccurate or misleading statements may affect any claims made against the associated policy. I verify I have read and understand all information contained in this application and that Gagliardi Insurance Services reserves the right to deny all or part of any coverage offered. I understand that this application only provides a summary of coverage and that full details of the coverage or a copy of the insurance policies offered or purchased can be provided upon request. Insurance requirements may vary by venue and state. I understand that I am responsible for ensuring that I have purchased adequate coverage based on the location of the event or other covered activities.

☐ ← **<u>Please Check</u>: I understand once my policy is paid for and coverage is bound, there are no deleting teams or refunds.**

Date: _____ Applicant Signature: _____

Print Name and Title: _____

Please sign and submit this application via mail, fax or e-mail along with your method of payment (check by mail / check or credit card by fax/email – forms attached)

Waiver of Liability, Release (sample)

For and in consideration of the undersigned participant's registration with _____ (Name of Organization) ("Organization") and being allowed to participate in events and member activities, participant and the parent(s) or legal guardian(s) of participant waive, release and relinquish any and all claims for liability and cause(s) of action, including for personal injury, property damage or wrongful death occurring to participant or participant's parent(s) or legal guardian(s) arising out of participation in events, or sports, and/or activities incidental thereto, whenever or however they occur and for such period said activities may continue, and by this agreement any such claims, rights, and causes of action that participant and/or participant's parent(s) or legal guardian(s) may have are hereby waived, released and relinquished, and participant and participant's parent(s)/guardian(s) do so on behalf of their heirs, executors, administrators and assigns.

Participant and participant's parent(s)/guardian(s) acknowledge, understand and assume all risks relating to events or sports participation and activities incidental thereto, and understand that activities incidental thereto involve risks to participant's and participant's parent('s)/guardian('s) person including bodily injury, partial or total disability, paralysis and death, and damages which may arise there from and that we have full knowledge of said risks. These risks and dangers may be caused by the negligence of the participant, participant's parent(s)/guardian(s)or the negligence of others, including the organization, its affiliates, members, event hosts, other participants, other parents and legal guardians, coaches, officials, sponsors, advertisers, owners and operators of the premises used to conduct any event and each of them, their officers, directors, agents and employees (collectively, "releasees"), and include risks arising from the conditions and use of facilities and related premises. I/We further acknowledge that there may be risks and dangers not known to us or not reasonably foreseeable at this time.

Participant and participant's parent(s)/guardian(s) acknowledge, understand and assume the risks, if any, arising from the conditions and use of facilities and related premises, whether as a participant or a spectator, including without limitation, the risks involved with participating in the Organization's activities. Participant and participant's parent(s)/guardian(s) further acknowledge and understand that included within the scope of this waiver and release is any cause of action (including any cause of action based on negligence) arising from the performance, or failure to perform, maintenance, inspection, supervision or control of said areas and for the failure to warn of dangerous conditions existing at said facilities, for negligent selection of certain releasees, or negligent supervision or instruction by releasees.

Participant and participant's parent(s)/guardian(s) acknowledge, understand The Organization reserves the right to photograph facilities, activities and program participants for potential future use. All photos remain the property of the Organization and may be used for publicity and promotional services.

Consent to Medical Treatment of Minor: I hereby give my consent to have the above applicant treated by a physician or surgeon in case of sudden illness or injury while participating in the above event. It is understood that the Organization provides no medical insurance for such treatment under its liability insurance coverage. Medical benefits for such treatments/injuries may be provided with proof of medical coverage purchased through the Organization. The location of the activity or the nature of the illness or injury may require the use of emergency medical personnel.

Participant and participant's parent(s)/guardian(s) agree if any claim for personal injury or wrongful death is commenced against releasees, he/she shall defend, indemnify and save harmless from any and all claims or causes of action by whomever or wherever made or presented for his/her personal injuries, property damage or wrongful death.

Participant and participant's parent(s)/guardian(s) acknowledge that they have been provided and have read the above paragraphs and have not relied upon any representations of releasees, that they are fully advised of the potential dangers and risks and understand these waivers and releases are necessary to allow the activities of the Organization to exist in its present form.

Participant Signature	Age	Date Signed
Participant Name (Print)		
Parent or Guardian Signature (if under 18)		Date Signed

Payment Authorization Form

Please choose one of the following payment options to complete payment
Payment will be processed upon receipt of application unless otherwise requested

Credit Card

Name (as it appears on the card):	
Credit Card Number: *Visa/MasterCard/Discover only*	
Expiration Date:	
V Code: 3 digit code on back of card	
Billing Address:	
Billing City, State, and Zip Code	

E-Check (Electronic Check)

Please fill out section below. Do NOT mail in check if you choose this option.

Bank Name: _____
Bank Account Type:_____ (*Checking, Savings, Business Check*)
Bank ABA Routing Number: _____
Bank Account Number: _____

Attach a copy of voided check here

***Required to process E-check**

(If the check does not fit, please provide a separate page with the copy of your VOIDED check)

Signature Required

I authorize Gagliardi Insurance Services, Inc. to charge my account in the amount of $_____ for insurance premium unless I, _____, notify
Gagliardi Insurance Services, Inc. of its cancellation by sending written notice either by email, fax, or mail.

Name (Print): _____ **Date**: _____

Signature: _____

California Office
950 S. Bascom Ave.
Suite 3010
San Jose, CA 95128

Pennsylvania Office
109 S. 13th St.
Suite 117B
Philadelphia, PA 19107

Email
sales@gsportsinsurance.com

Phone
800-995-9768

Website
gsportsinsurance.com

Submission Options:

- Send to Pennsylvania office listed above
- Scan and email to sales@gsportsinsurance.com
- Fax to 408-414-8199

THANK YOU from The Gagliardi Team