



2018

Tournament Insurance Application

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Program Coverage Summary

\$ 2,000,000	Aggregate per Organization
\$ 1,000,000	Personal and Advertising Injury
\$ 1,000,000	Each Occurrence
\$ 300,000	Damage to Rented Premises
\$ 25,000	Participant Accident Medical
\$ 10,000	Accidental Death and Dismemberment
\$ 100	Deductible – Accident Medical



Tournament Insurance Application

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)

Conference Name: _____
Organization/Association Name: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____
Email: _____
Individual Responsible For Insurance: _____
President of Organization: _____

Add an Additional Contact Allowed to Request Information

Name: _____ Phone: _____ Email: _____

New Policy

(New to Gagliardi)

Renewal

(Renewing a policy)

Adding Teams

(Adding to an existing policy)

Underwriting Questions

- Yes___ No___ Does your organization adopt or adhere to rules and regulations created by a nationally recognized rulemaking organization? (AAU, MLB, NBA, NCAA, FIFA, etc...)
- Yes___ No___ Do any covered activities involve pole-vaulting or any other track and field activity that involves thrown objects? (If Yes, contact our office for the supplemental application)
- Yes___ No___ Do any covered activities involve using a firearm that does not take place on a premises specifically designed for the purpose of discharging firearms? (If Yes, contact our office for the supplemental application)
- Yes___ No___ Have you or the team, league, or organization had any claims filed against it within the last four years? (If Yes, please provide a carrier generated loss runs report)
- Yes___ No___ Is there an overnight exposure associated with the team, league, camp, or clinic?
- Yes___ No___ Do you require a completed waiver from all participants or agree to require the attached waiver?
- Yes___ No___ N/A___ Is a parent's signature required for minors?
- Yes___ No___ Do you have a written incident report procedure in place or agree to put one in place? (If No, please contact our office for an example)
- Yes___ No___ Do any covered activities involve the use of a pool?



Tournament Coverage Worksheet									
Sport	# of Teams 15 and Under		Rate per Team 15 and Under		# of Teams 16 and Over		Rate per Team 16 and Over		Premium Due
Baseball		x	\$16.91	+		x	\$18.48	=	
Softball		x	\$16.91	+		x	\$18.48	=	
T-Ball		x	\$16.32	+		x	\$17.89	=	
Basketball		x	\$16.41	+		x	\$17.98	=	
Volleyball		x	\$15.83	+		x	\$17.40	=	
Lacrosse		x	\$21.72	+		x	\$23.29	=	
Soccer (Youth)		x	\$17.94	+		x	\$19.51	=	
Football (Flag/Touch)		x	\$17.83	+		x	\$19.40	=	
Football (Contact 19U)		x	\$25.43	+		x	\$27.00	=	
Hockey (Ice 19U)		x	\$24.49	+		x	\$26.06	=	
Hockey (Field/Inline)		x	\$19.48	+		x	\$21.05	=	
Dodgeball / Kickball		x	\$16.41	+		x	\$17.98	=	

Total Premium Due: \$ _____
 (Minimum Premium is \$275)

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.**

<p>_____ Additional Insured (Full Name)</p> <p>_____ Address</p> <p>_____ City, State, Zip</p> <p>_____ Relationship to Insured</p>	<p>_____ Additional Insured (Full Name)</p> <p>_____ Address</p> <p>_____ City, State, Zip</p> <p>_____ Relationship to Insured</p>
<p>_____ Additional Insured (Full Name)</p> <p>_____ Address</p> <p>_____ City, State, Zip</p> <p>_____ Relationship to Insured</p>	<p>_____ Additional Insured (Full Name)</p> <p>_____ Address</p> <p>_____ City, State, Zip</p> <p>_____ Relationship to Insured</p>
<p>_____ Additional Insured (Full Name)</p> <p>_____ Address</p> <p>_____ City, State, Zip</p> <p>_____ Relationship to Insured</p>	<p>_____ Additional Insured (Full Name)</p> <p>_____ Address</p> <p>_____ City, State, Zip</p> <p>_____ Relationship to Insured</p>
<p>_____ Additional Insured (Full Name)</p> <p>_____ Address</p> <p>_____ City, State, Zip</p> <p>_____ Relationship to Insured</p>	<p>_____ Additional Insured (Full Name)</p> <p>_____ Address</p> <p>_____ City, State, Zip</p> <p>_____ Relationship to Insured</p>

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



Tournament Insurance Application

- 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 _____

<u>ALL PREMIUMS ARE FULLY EARNED AT POLICY INCEPTION</u>	
No Refunds	
Total Amount From Premium Due Columns: \$ _____	
Agency Fee (non-refundable): \$ <u>30</u>	
Expedite Fee (Optional 24hr Rush Delivery):	<input type="checkbox"/> \$50 (optional)
<i>(Normal Processing is Approximately 5 Business Days)</i>	
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.

← **Please Check: 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)



Payment Options

- Payment Link (Electronic Payment) check box and we will forward payment link via email upon review of application
- Check by mail
- Visa or MasterCard (Authorization form attached – next page)
- Check by fax (E-Check) Please fill out section below and attach a voided check (required) in the space provided. Do NOT mail in check.

I, _____ authorize Gagliardi Insurance Services, Inc. to charge my account in the amount of \$_____ for insurance premium.

My account information is as follows:

Bank Name: _____

Bank Account Type: _____ (Checking, Savings, Business Check)

Bank ABA Routing Number: _____

Bank Account Number: _____

This payment authorization is valid and to remain in effect unless I, _____, notify Gagliardi Insurance Services, Inc. of its cancellation by sending written notice either by email, fax, or mail.

ATTACH CHECK HERE

Signature _____

Date _____

Printed Name _____

Credit Card Authorization Form

Name (as it appears on the card):	
Credit Card Number: <i>Visa/MasterCard/Discover only</i>	
Expiration Date:	
V Code: 3 Digit code on back of the credit card	
Amount to Be Billed: Use total premium including fees	
Billing Address:	
Billing City, State, and Zip Code	
Billing Date: Will be processed upon review unless otherwise noted	
Name of Insured / Policy Holder: Name of Team/League	

I, _____, authorize the use of my credit card described above for charges related to the services and products provided by Gagliardi Insurance Services, Inc.

Cardholder's Signature

Date



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@gssportsinsurance.com

Phone

800-995-9768

Website

gssportsinsurance.com

Submission Options:

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

THANK YOU from The Gagliardi Team