



PONY Baseball / Softball, Inc. Insurance Application

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PONY Insurance Requirements

- ✓ Teams must be PONY registered
- ✓ General Liability & Accident Medical Required
 - Combined Rates - (Prices include GL & MED)
- ✓ Options for Accident Medical Limit (Choose one)
 - \$100K (Option #1)
 - \$250K (Option #2)
- ✓ PONY added as certificate holder (page #7)

Program Coverage Summary

General Liability (Coverage for fields, facilities, tournaments, etc...)

\$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
\$2,000,000	Products/Completed Operations	\$ -0-	Medical Expense Coverage
\$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)

Accidental Medical (Excess coverage for your participants)

\$100,000	Accidental Medical	- OR -	\$250,000	Accidental Medical
\$10,000	Accidental Death & Dismemberment		\$10,000	Accidental Death & Dismemberment
\$3,000	Accidental Dental Benefit		\$3,000	Accidental Dental Benefit



Broker Information

(If Not Applicable, Skip This Section)

Name of Agency / Brokerage: _____ Broker Code: _____

Name of Contact / Agent: _____

Mailing Address of Agency / Brokerage: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

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

*This will be the final year Gagliardi Insurance Services will be issuing commission on our PONY program clients.

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: _____

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 | Did you receive, and do you agree to implement the PONY Risk Management Guidelines |
| Yes | No | If NO, do you agree to obtain your copy at www.pony.org and implement |
| Yes | No | Does your organization require a 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 excluded from the policy. |
- Initials _____

For discounted background checks, please visit www.pony.org or contact our office for details





Program Rates

1. Please pick either **Option #1 OR Option #2**.
2. Please indicate # of teams in each age category, all teams must have same Deductible option.
3. Calculate Premium Due by multiplying "# of teams" by "Deductible Option"
(Rate varies by age/option/deductible)

PLEASE NOTE: Once your policy is bound premium is fully earned and there is no deleting or refunds for teams. You may add teams at any time throughout the policy term.

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

Baseball Rates - (\$100K Accident Medical Benefit / General Liability)

Age Group	# of Teams		\$50 Deductible	\$100 Deductible	\$250 Deductible		Premium Due
10 and Under		x	\$81	\$75	\$71	=	\$
12 and Under		x	\$83	\$78	\$73	=	\$
16 and Under		x	\$110	\$105	\$94	=	\$
19 and Under		x	\$184	\$158	\$140	=	\$
23 and Under		x	\$293	\$245	\$214	=	\$

Softball Rates - (\$100K Accident Medical Benefit / General Liability)

Age Group	# of Teams		\$50 Deductible	\$100 Deductible	\$250 Deductible		Premium Due
12 and Under		x	\$72	\$70	\$67	=	\$
16 and Under		x	\$100	\$95	\$88	=	\$
19 and Under		x	\$121	\$113	\$104	=	\$
23 and Under		x	\$188	\$174	\$153	=	\$

Champions Division - (Special Needs Program – Baseball/Softball)

Age Group	# of Teams		\$50 Deductible	\$100 Deductible	\$250 Deductible		Premium Due
All Ages		x	\$81	\$75	\$71	=	\$

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

Baseball Rates – (\$250K Accident Medical Benefit / General Liability)

Age Group	# of Teams		\$50 Deductible	\$100 Deductible	\$250 Deductible		Premium Due
10 and Under		x	\$86	\$82	\$76	=	\$
12 and Under		x	\$89	\$85	\$78	=	\$
16 and Under		x	\$123	\$114	\$104	=	\$
19 and Under		x	\$213	\$180	\$158	=	\$
23 and Under		x	\$343	\$285	\$245	=	\$

Softball Rates – (\$250K Accident Medical Benefit / General Liability)

Age Group	# of Teams		\$50 Deductible	\$100 Deductible	\$250 Deductible		Premium Due
12 and Under		x	\$77	\$75	\$70	=	\$
16 and Under		x	\$111	\$105	\$95	=	\$
19 and Under		x	\$135	\$127	\$113	=	\$
23 and Under		x	\$203	\$189	\$166	=	\$

Champions Division - (Special Needs Program – Baseball/Softball)

Age Group	# of Teams		\$50 Deductible	\$100 Deductible	\$250 Deductible		Premium Due
All Ages		x	\$86	\$82	\$76	=	\$





Additional Coverage Options

- ✓ These coverages are offered to better protect your association or may be required by locations your association is using

Excess Liability Coverage

- ✓ Increases your General Liability (Aggregate & Per Occurrence) by \$4 million each (Increases Aggregate / Per Occurrence: \$2M/\$1M → \$6M/\$5M)
- ✓ "# of teams" must match total number of teams input on p. 3 of application
- ✓ ***Recommended for larger organizations or associations who may be using high school, college or minor league stadiums**
- ✓ Select "Yes" or "No" if you wish to elect Excess Liability Coverage:
Yes No If selected "Yes," proceed to complete fields below:

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

Catastrophic Medical Coverage

- ✓ Must select Option 2 on p. 3 and input total number of teams on P. 3
- ✓ Multiply "Rate per Team" times "# of Teams" to equal premium due for Catastrophic Medical Coverage
- ✓ Increases Accident Medical benefit limit to \$500,000 (Must sign pg. 8)
- ✓ ***Recommended for larger associations who may run the risk of exhausting the \$250,000 medical limit selected on p. 3**
- ✓ Check "Yes" or "No" if you wish to elect Catastrophic Medical Coverage:
Yes No If selected "Yes," proceed to complete fields below:

Catastrophic Medical Limit	Deductible	Rate per Team		# of Teams		Premium Due
\$500,000	\$25,000	\$15	x		=	\$

Playing Field Coverage

- ✓ This coverage extends the liability policy to cover your organizations owned playing fields or fields which you are responsible for 24/7.
- ✓ Check "Yes" or "No" if you wish to elect Playing Field Coverage:
Yes No If selected "Yes," proceed to complete fields below:

Playing Field Underwriting Questions

- 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 (<u>owned</u>)		Premium Due
\$165	x		=	\$





Directors & Officers Coverage Application

- ✓ This coverage protects your board members and volunteers in the event of litigation arising against the decision makers of your association with a \$1,000,000 limit
- ✓ For multiple associations, make as many copies of this page as required
- ✓ Select "Yes" or "No" if you wish to elect Directors & Officers Coverage:
 Yes No If selected "Yes," proceed to complete this page of application.

Directors & Officers Limit	Deductible	Rate per Board		# of Boards		Premium Due
\$1,000,000	\$500	\$345	x		=	\$

Conference Name: _____
 Association Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Presidents Name: _____

Directors & Officers Underwriting Questions

- Yes No Have any loss payments been made under any prior or current D&O or similar insurance?
- Yes No 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 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?

Cyber Liability Endorsement

- ✓ If your organization is collecting participant data or sign up fees over the internet, we highly suggest this endorsement
- ✓ Select "Yes" or "No" if you choose to elect Cyber Liability Coverage:
 Yes No If selected "Yes," proceed to complete fields below:

Cyber Liability Limit	Deductible	Rate per Board		# of Boards		Premium Due
\$100,000	\$500	\$100	x		=	\$

Cyber Liability Benefit Summary:

\$100 K Regulatory Action Limit For:	\$100K Privacy Event Limit For:
<ul style="list-style-type: none"> ✓ Legal Fees incurred in response to a privacy loss ✓ Regulatory Action investigation 	<ul style="list-style-type: none"> ✓ Notifying individuals whose information was compromised ✓ Credit Monitoring
<ul style="list-style-type: none"> ✓ Fines and penalties the organization is required to pay resulting from a Regulatory Action 	<ul style="list-style-type: none"> ✓ Legal fees to determine compliance requirements when information is compromised
<ul style="list-style-type: none"> ✓ A fund to provide compensation to individuals as required by a Regulatory Action 	<ul style="list-style-type: none"> ✓ 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 writing of any changes in Board of Directors.

Date: _____ Signature: _____





Fidelity Bond Application

- ✓ A Fidelity Bond protects your organization against employee/volunteer fraud or dishonesty, but will not cover cash/untraceable funds.
- ✓ Each Fidelity Bond covers 5 Board Members / volunteers 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 necessary to obtain coverage for all Boards, Board Members or volunteers you deem fit to place on this policy
- ✓ Select "Yes" or "No" if you choose to elect Fidelity Bond Coverage:

Yes No If selected "Yes," proceed to complete fields below:

Fidelity Bond Limit	Deductible	Rate per Bond		# of Bonds		Premium Due
\$35,000	\$500	\$180	x		=	\$

Fidelity Bond Underwriting Questions

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

Board Association Name: _____

5 Association Positions to be on Policy:
(Position Title)

Full Name of Person on Policy:

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. This coverage protects your equipment against theft, vandalism or weather-related damage.
- ✓ Buildings and food products are NOT covered under this policy.
- ✓ Minimum Premium for Sports Equipment Coverage is \$250 gives your association a \$10,500 limit of protection.
- ✓ Select "Yes" or "No" if you choose to elect Sports Equipment Coverage:
 Yes No If selected "Yes," proceed to complete fields below:

Association Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Presidents Name: _____

Deductible	Insert Equipment Value		Rate per \$1 of Equipment		Premium Due (Round to nearest whole dollar)
\$500		x	\$0.0238	=	\$

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

<u>Equipment</u>	<u>Serial Number</u>	<u>Equipment</u>	<u>Serial Number</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Complete address where equipment is stored:

Address: _____

City: _____ State: _____ Zip Code: _____

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 (check all that apply):
 Burglar Alarms Fire Alarms Automatic Sprinklers None

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





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"**





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

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

<u>ALL PREMIUMS ARE FULLY EARNED AT POLICY INCEPTION</u>	
No Refunds, Deleting Teams or Coverages	
<p>Total Amount from Premium Due Columns: \$ _____</p> <p>Agency Fee (non-refundable): \$30</p> <p>Expedite Fee (Optional 24hr Rush Delivery): \$50 (optional) <small>(Normal Processing is Approximately 5 Business Days)</small></p> <p>Total Amount Due For Premiums and Fees: \$ _____</p>	

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/participants 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 (Payment link via email / check by mail / e-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: <i>*Visa/MasterCard/Discover only</i>	
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 completed checks 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: _____



How to Reach Us

California Office

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

Pennsylvania Office

109 S. 13th St.
Suite 117B
Philadelphia, PA19107

Submission Options:

Send to Pennsylvania Office listed above

or

Scan and email to:
sales@gsportsinsurance.com

or

Fax to: 408-414-8199

Website: gsportsinsurance.com

Phone: +1 (800)-995-9768

Email: sales@gsportsinsurance.com