



Camps & Clinics Application

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Program Coverage Summary

\$ 2,000,000	Liability Aggregate
\$ 1,000,000	Personal and Advertising Injury
\$ 1,000,000	Liability Each Occurrence
\$ 300,000	Damage to Rented Premises
\$ 25,000	Accident Medical Limit
\$ 10,000	Accident Death & Dismemberment
\$ 100	Medical Deductible per occurrence

Additional limits, sports and coverage available, please contact our office for details.

Optional General Liability (GL) Coverages:

- > **Medical Expense Limit** (Any one person) - Spectators Only - \$5,000 Limit
1% of GL Premium or \$50 per Subscribing Member (whichever is higher)
- > **Abuse or Molestation** - \$1,000,000 Occurrence/\$2,000,000 Aggregate Limit
6% of GL Premium or \$500 per Subscribing Member (whichever is higher)*

* A completed supplemental application is required.

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 Name: _____

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?



Effective Dates, Sports Type(s), and Liability Coverage

Requested Policy Period: Start: _____ End: _____
(Effective Dates)

If multiple non-consecutive camps, please list all appropriate dates:

Start: _____ End: _____

Start: _____ End: _____

Please List All Applicable Sports and Activities

Coverage Worksheet							
	Number of Participants		Number of Days		Rate per Participant		Premium Due
Clinics/Day Camps (Excluding Cheerleading) Daily		X		X	\$ 1.54	=	
	Number of Participants		Number of Weeks		Rate Per Participants		Premium Due
Clinics/Day Camps (Excluding Cheerleading) Weekly (3-7 consecutive days)		X		X	\$ 4.85	=	
	Number of Participants		Number of Days		Rate Per Participants		Premium Due
Day Camps - Cheerleading		X		X	\$ 5.74	=	

Total Premium Due: \$ _____

Note: Minimum Premium is \$275.00



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: _____

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

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)



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 completed checks.

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



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



How to Reach Us

California Office

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

Submission Options:

Send to California 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