

Amateur Sports Accident Insurance Request for Proposal

Coverage terms, conditions, limitations and exclusions may vary
and may not be available in all states.

Submission Date: _____	When would you like to receive your quote? _____
Requested Effective Date: _____	Requested Commission: _____

Prospective Policyholder Information		
Name: _____		
Physical Address: _____		
City: _____	State: _____	Zip Code: _____
Telephone Number: _____	Website: _____	

Description of Activities	
Nature of Covered Activities _____	
Term of Coverage Requested: <input type="checkbox"/> Annual <input type="checkbox"/> Short Term (Please specify dates of coverage needed) From _____ To _____	
Duration of Coverage: <input type="checkbox"/> Season <input type="checkbox"/> Tournament <input type="checkbox"/> Specific Event	
Number of Active days (e.g., # of events, games, tournaments): _____	Number of Teams: _____
<input type="checkbox"/> International Travel (specify) _____	

Description of Participants				
Please complete the census using the following table. Indicate the number of participants in each sport or activity by the age groups shown below. Attach a separate sheet, if needed.				
Sport/Activity	Ages 12 and under	Ages 13-15	Ages 16-18	Ages 19 and over
Archery				
Baseball				
Basketball				
Bowling				
Boxing				
Cheerleading (Recreational)				
Cheerleading (Competitive)				
Cross Country				
Diving				
Downhill Skiing				
Field Hockey				
Football (Touch/Flag)				
Football (Tackle)				
Golf				
Gymnastics				
Hockey (Street)				
Hockey (Ice)				
Ice Skating				

Sport/Activity	Ages 12 and under	Ages 13-15	Ages 16-18	Ages 19 and over
Martial Arts (please specify style)				
Mud/Color Runs				
Lacrosse				
Paintball				
Racquetball				
Rowing				
Rollerblading				
Rugby				
Shooting (Rifle/Pistol/Skeet/Trap)				
Skateboarding				
Soccer				
Softball				
Surfing				
Swimming				
Tennis				
Track and Field				
Volleyball				
Water Polo				
Water Skiing				
Weightlifting				
Wrestling				
Other (please specify)				
Percentage of Participants by gender: Male _____% Female _____%				

Benefits Schedule and Principal Sum Amounts				
<input type="checkbox"/> Accidental Death & Dismemberment <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> Other \$ _____ <i>Death or dismemberment loss must occur within 365 days of the accident.</i>				
<input type="checkbox"/> Paralysis <input type="checkbox"/> Coma <input type="checkbox"/> Heart & Circulatory <i>The Paralysis, Coma and Heart & Circulatory principal sum amounts will be the same as the Accidental Death & Dismemberment principal sum.</i>				
<input type="checkbox"/> Accident Medical Expense				
Benefit Maximum	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> Other \$ _____
Benefit Type	<input type="checkbox"/> Full Excess	<input type="checkbox"/> \$100 Primary Excess	<input type="checkbox"/> Primary	
Deductible	<input type="checkbox"/> Corridor <input type="checkbox"/> Vanishing (Integrated)			
	<input type="checkbox"/> \$0	<input type="checkbox"/> \$100	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$ _____
Benefit Period	<input type="checkbox"/> 52 weeks	<input type="checkbox"/> 104 weeks		
First expense must be incurred within:	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days of the Covered Accident	
<input type="checkbox"/> Expanded Sports Medical benefit for sports conditions for treatment of bursitis, sprains, hernia, strains, muscle tears, tendonitis and repetitive motion injuries.				
<input type="checkbox"/> Emergency Evacuation <input type="checkbox"/> Repatriation				

Current Coverage

Insurance Company: _____ **Note:** Please attach a copy of the expiring policy.

Has the current plan design been the same over the past five (5) years? If no, please describe the benefit/plan changes from year-to-year in detail: _____ Yes No

Premium and Loss History: Please provide the premium and paid loss information for the past five (5) years. Be sure to include the validation date for the paid claim data (Note: The paid loss data should be within 60 days of the Submission Date of this request for proposal) and attach copies of the carrier loss runs that support the paid claims data.

Date through which claims are paid: _____

Policy Year	Premium	Losses Paid	Deductible Amount	Carrier

Producer Information

Producer Name:		Contact Person:	
Agency Legal Name:			
Address:			
City:		State:	Zip Code:
Telephone Number:		Fax Number:	
Email:		Website:	

Note: Business can only be bound, and commission payable, if you and your agency are properly licensed and appointed where required.

Terms of Acknowledgement and Signature: This Request for Proposal (RFP) is not a contract of insurance. No coverage is bound or afforded by this RFP. A proposal will be based on information included on an attached to this RFP. The undersigned hereby certifies that this information accurately represents the facts and that no requested information has been misrepresented, misstated, omitted, or altered. In the event that the undersigned becomes aware of facts that would have a material effect on the proposed coverage, any such facts or information will be immediately reported to carrier. I understand that if information material to the underwriting of this coverage changes, the carrier reserves the right to pursue, without limitation, an adjustment of premiums or coverage, in accordance with such correct facts or information and any other remedies available through operation of law or at equity.

Electronic Signature: <i>Please type your First and Last Name.</i>	Title: _____ Date: _____
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I understand that checking this box constitutes a legal signature confirming that I understand and agree to the above Terms of Acknowledgement. **Please do not forget to type your name in the E-Signature section.**

Please email completed form to SpecialRiskSolutions@BerkleyAH.com

Insurance provided is underwritten by Berkley Life and Health Insurance Company and/or StarNet Insurance Company, both member companies of W. R. Berkley Corporation and both rated A+ (Superior) by A.M. Best. The policies contain exclusions and limitations and may not be available in all states. For complete details, please contact us at SpecialRiskSolutions@BerkleyAH.com.