

PLAN HIGHLIGHTS

Sports Accident Insurance Coverage

Up to \$1,000,000 Accident Medical Expense Maximum
 (Subject to Exclusions and Limitations)

\$10,000.00 Accidental Dismemberment Benefit

Up to \$10,000.00 Accidental Death Benefit

Dental Limit Included In Overall Policy Maximum

COVERAGE DESIRED

Primary Excess over \$ _____ Full Excess

MEDICAL BENEFIT MAXIMUM DESIRED

\$250,000 \$500,000 \$ 1,000,000 Other _____

BENEFIT PERIOD DESIRED

1 Year 2 Year 3 Year

DEDUCTIBLE DESIRED

None \$25 \$50 Other _____

ACCIDENTAL DEATH BENEFIT DESIRED

\$5,000 \$10,000

No Name List

No Tryout Charge

Age Group:	“A”—12 and under	REQUESTOR: _____
	“B”—13 to 15	ADDRESS: _____
	“C”—16 to 18	_____
	“D”—19 and over	PHONE: _____

Name of Sports	Age Group	Number of Teams	Number of Players	Effective Date	Termination Date	H.O. Use
Total Premium — \$						

Number of Players Subject to Audit

Team Prices & League Discounts are available for: Baseball, Basketball, Football & Softball

IMPORTANT—TEAR OFF AND RETURN FOR QUOTATION

REQUEST FOR POLICY ISSUE FOR: _____, herein referred to as a Requestor, and agrees to be bound by the applicable terms and conditions. In New Jersey and South Carolina: Requestor agrees to be a participant in the Direct Marketers Insurance Trust.

The Requestor agrees to make insurance available to its eligible members in accordance with the benefits and provisions of the Master Policy.

1. PLAN: PRIMARY EXCESS OVER \$ _____ FULL EXCESS
- | | | | |
|---------------------------|----------|-----------------------------------|--------------|
| Accident Medical Expense: | | Accidental Dismemberment Benefit: | |
| Maximum Amount: | \$ _____ | Principal Sum: | \$ 10,000.00 |
| Deductible Amount: | \$ _____ | Accidental Death Benefit: | \$ _____ |
| | | Benefit Period: | _____ years |

Eligibility and Classification of Insureds: All players, coaches and managers are insured for a covered injury sustained while they are: (1) participating in any scheduled, games or practice sessions; or (2) traveling to, during or after such activities as a member of a group in transportation arranged by the Requestor, or (3) traveling directly to or from the Insured's home premises and the site of such activities. Coverage during pre-season tryouts, if checked "Yes" below, will extend to every player, manager and coach involved.

2. Are Pre-Season Tryouts Covered Yes No
3. Insurance Effective Date: The date shown below at 12:01 a.m. local time at the address of the Requestor.

(This space for Administrative Use Only)	Effective Date:	Requestor No. JOS-
	Expiration Date:	Policy Number: JOS-000000

4. Requestor Name _____
- Address _____
- City _____ State _____ Zip _____

5.

Name of Team	Sport	Age Group	No. of Teams	No. of Players	Team Premium

Note: The total premium must be submitted with this Request. Total Premium \$ _____

6. Individual whose signature appears below is authorized to certify injuries to be recognized by the Company. (If more than one, list on a separate piece of paper.)

SPECIAL NOTES:

We hereby request from Mutual of Omaha Insurance Company for a Sports Accident Insurance Policy. We understand that insurance will be in force as of the effective date indicated above, if this Request for Policy Issue is accepted by the Company and the required premium is received by the Company

Official's Name: _____ Signature/Title _____
(please print)

Please return to:

Hobbs Group, LLC/Kirklin & Co
PO Box 540673
Omaha, NE 68154
402-498-0464
fax 402-492-8421

LOCAL ADMINISTRATION

Name _____

Tax I.D. or Soc. Sec. No. _____

Address _____

City _____ State _____

Zip Code _____ Telephone _____

Signature (Licensed Agent) _____

SPORTS GENERAL LIABILITY APPLICATION

\$1,000,000.00 OCCURRENCE/\$2,000,000.00 AGGREGATE (OCCURRENCE FORM)

Chicago Insurance Company

APPLICATION TO THE SPORTS ASSOCIATION PURCHASING GROUP

(Please PRINT or TYPE)

Full Name of Organization/Association (Applicant) _____ Date of Application: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Effective Date Requested: _____ Expiration Date: _____ Phone Number: _____ Fax Number: _____

Type of Activity: League/Team Camp Clinic _____ Dates of Camps/Clinics _____ Tournament

Coverage Desired: Occurrence Form Youth Adult Optional Coverages: Hired and Non-owned Automobile
 Limited Physical/Sexual Assault Coverage
 Medical Payments Coverage

Rates are included for Fire Damage Legal Liability Coverage.
 To exclude coverage check box: No

Premises/Location of Operations: (Please list all premises & locations & addresses for each.)

1. _____ Owned Leased
 2. _____ Owned Leased

If leased, are you responsible for maintaining building and premises? Yes No **Gymnastics Only**
 Do you rent public facilities for your sporting event(s)? Yes No **To be eligible, rosters must be kept for**
 If YES, do you share with other parties? Yes No **all entrants & all entrants must sign**
waiver releases.

DOES THE APPLICANT HAVE UNDERLYING ACCIDENT/MEDICAL COVERAGE? Yes No
 LIMITS: \$100,000 \$250,000 \$500,000 \$1,000,000 \$5,000,000 OTHER\$ _____

OPERATIONS/EXPOSURES:

ACTIVITY	LEAGUE		SPORTS CAMPS/CLINICS		# OF COACHES (If to be covered)
	(# of Participants)		Please indicate Day or Overnight (# of Participants)		
	Youth	Adult	Youth	Adult	
AEROBICS CLASSES	_____	_____	_____	_____	_____
BASEBALL	_____	_____	_____	_____	_____
BASKETBALL	_____	_____	_____	_____	_____
BOWLING	_____	_____	_____	_____	_____
BOXING (Youth Only)	_____	_____	_____	_____	_____
BROOMBALL	_____	_____	_____	_____	_____
CHEERLEADERS (Youth Only)	_____	_____	_____	_____	_____
CRICKET	_____	_____	_____	_____	_____
DANCE CLASSES	_____	_____	_____	_____	_____
FIELD HOCKEY	_____	_____	_____	_____	_____
FLAG FOOTBALL	_____	_____	_____	_____	_____
GYMNASTICS (Youth Only)	_____	_____	_____	_____	_____
HOCKEY	_____	_____	_____	_____	_____
ICE SKATING	_____	_____	_____	_____	_____
LACROSSE	_____	_____	_____	_____	_____
MARTIAL ARTS	_____	_____	_____	_____	_____
SELF DEFENSE (Adults Only)	_____	_____	_____	_____	_____
SOCCER	_____	_____	_____	_____	_____
SOFTBALL	_____	_____	_____	_____	_____
SWIMMING	_____	_____	_____	_____	_____
TACKLE FOOTBALL (Youth Only)	_____	_____	_____	_____	_____
TENNIS	_____	_____	_____	_____	_____
ULTIMATE FRISBEE	_____	_____	_____	_____	_____
VOLLEYBALL	_____	_____	_____	_____	_____
WRESTLING (Youth Only)	_____	_____	_____	_____	_____
TRACK & FIELD	_____	_____	_____	_____	_____
* OTHER SPORTS AVAILABLE	_____	_____	_____	_____	_____

(Call for Details)

APPLICANT INCURRED ANY PRIOR LOSSES? Yes No If yes, explain details and amount paid for current year and three prior years.

ADDITIONAL INSURED: (Please list complete name and address for each additional insured as well as all Premises/ Location of each additional insured.)

1. _____
2. _____

100% Participation Required - All Players are Covered - NO Name Lists Required. The Named insured warrants that accident medical insurance in the amount indicated above will be in full force and effect for each participant in all athletic program(s) to be covered. If no underlying accident medical coverage is in force, injuries or death to athletic participants will be excluded.

Coverage is underwritten by Chicago Insurance Company, a Fireman's Fund Company, through the Sports Association Purchasing Group. The Sports Association Purchasing Group is organized pursuant to legislation enacted by Congress known as the Federal Liability Risk Retention Act of 1986, and is domiciled in Illinois. Receipt of a completed application and premium, and acceptance and confirmation by the Underwriting office will entitle you to membership in the Sports Association Purchasing Group. Coverage is effective on the proposed effective date or the date completed application and proper premium are received by the plan Administrator, whichever is later.

THE APPLICANT DECLARES that to the best of their knowledge the information contained in the application is true and that no material facts have been suppressed or misstated. THE APPLICANT UNDERSTANDS that incorrect or incomplete statements or information could void their protection.

X _____
Signature of Applicant Date Typed/Printed Name and Title

X _____
Signature of Licensed Resident Agent

THIS IS NOT A BINDER OF COVERAGE

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT.

Premium Calculation:

_____ # of Participants		<u>YOUTH</u>	<u>ADULT</u>
X \$ _____ Premium Rate per Participant		TOTAL CAMPER DAYS - DAY - _____	_____
= \$ _____ Subtotal		TOTAL CAMPER DAYS - RESIDENT - _____	_____
+ \$ _____ Additional Insureds (if any) at \$25.00 Each			
= \$ _____ Total Premium (\$300 minimum for Leagues\Teams.)			
			(\$200 minimum for Camps\Clinics\Tournaments.)

1. Complete this application.
2. Enclose check or money order.
3. Mail completed application and premium to:

Please return to:
Hobbs Group, LLC/Kirklind & Co
 PO Box 540673
 Omaha, NE 68154
 402-498-0464
 fax 402-492-8421

Company Use Only			
N <input type="checkbox"/>	R <input type="checkbox"/>	Comm _____%	
Pd <input type="checkbox"/>	B _____		
Holder#	_____		