



## Clubs/Groups Insurance Request for Quote

Instructions to obtain a Quote:

1. Complete form entirely to receive a quote. If the form is not completed, additional information will have to be attained before quoting.
2. Save completed form to your computer
3. Please send this form to: Email: [smic\\_information@amwins.com](mailto:smic_information@amwins.com), Fax: (715) 344-6126  
Or mail to: Special Markets Insurance Consultants, Inc., 1055 Main Street, Suite 101, Stevens Point, WI 54481  
Phone: (800) 727-7642

*Request for quote form must be completed and returned for underwriter review. Submission of this form does not guarantee coverage. Quote will be offered if risk meets Underwriting Guidelines. Payment of premium is required to bind coverage.*

### SUBMISSION REQUIREMENTS

1.  Currently valued, carrier-generated Loss Runs for the last three years and copy of the expiring policy(ies).
2.  Copy of rental agreement or contract to rent or use venue

### ACCOUNT INFORMATION

Named Insured \_\_\_\_\_  
(to be shown on policy declarations page)

Physical Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Fax \_\_\_\_\_ Website \_\_\_\_\_

Mailing Address \_\_\_\_\_

Location Address(es) (please attach additional pages if needed) \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_

Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Activity Start Date \_\_\_\_\_ Activity End Date \_\_\_\_\_

Named Insured is:  Individual  Partnership  Corporation  Association  LLC  Non-Profit  
 Other: \_\_\_\_\_ Tax Status:  Taxable or  Tax Exempt 501(c) \_\_\_\_\_

Years this entity in business \_\_\_\_\_ Years experience for this owner \_\_\_\_\_

Total Assets \_\_\_\_\_ Fund Balance \_\_\_\_\_ Annual Salary/Wages Expense \_\_\_\_\_

**Coverage Requested:**  Accident Medical Medical Limits:  \$10,000  \$25,000  Other Limit \$ \_\_\_\_\_  
Accident Medical Deductible Options:  \$0  \$100  \$250  \$500  \$1,000  Other Limit \$ \_\_\_\_\_

- Participant General Liability (Participants & spectators are included, accident coverage is required and Section E must be completed)  
Limits of Insurance Requested \$ \_\_\_\_\_
- Spectator General Liability (if checked, Section E must be completed)  
Limits of Insurance Requested \$ \_\_\_\_\_
- Abuse & Molestation (complete Section C) Limits of Insurance Requested \$ \_\_\_\_\_
- Hired/Non-Owned Auto Cost of Hire: \_\_\_\_\_
- Miscellaneous Equipment Coverage (Inland Marine) Limits of Insurance Requested \$ \_\_\_\_\_
- Directors & Officers Coverage (complete Section D) FEIN \_\_\_\_\_

**Type of Organization**  Club, Group or Association (complete Section A)  
 Non-Sport Camp or Trip (complete Section B)

### SECTION A – Club, Group or Association Underwriting Information

Describe all activities you are requesting insurance coverage for: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Age(s)	Number of Participants
Ages 12 & Under	_____
Ages 13 – 15	_____
Ages 16 – 18	_____

Age(s)	Number of Participants
Ages 19 & up	_____
Volunteers	_____

**SECTION B – Non-Sport Camp or Trip Underwriting Information**

Type of Camp (please check all that apply):  Day  Overnight\*  Trip  Youth  Adult  Special Needs  
 Other (specify): \_\_\_\_\_ Describe all activities of camps/trips: \_\_\_\_\_

**CAMP OR TRIP LOCATION(S) / ACTIVITIES**

Name and Address of Camp or Trip Location	Starts			Ends			No. of Days	Age Range	Estimated Number to be Insured
	MO	DAY	YR	MO	DAY	YR			
<input type="checkbox"/> Day <input type="checkbox"/> Overnight*								12 & Under	
								13-15	
								16-18	
								19 & Over	
								Volunteers	
<input type="checkbox"/> Day <input type="checkbox"/> Overnight*								12 & Under	
								13-15	
								16-18	
								19 & Over	
								Volunteers	
<input type="checkbox"/> Day <input type="checkbox"/> Overnight*								12 & Under	
								13-15	
								16-18	
								19 & Over	
								Volunteers	
<input type="checkbox"/> Day <input type="checkbox"/> Overnight*								12 & Under	
								13-15	
								16-18	
								19 & Over	
								Volunteers	

\*Section C will need to be completed for any overnight exposure

**Section C - Abuse & Molestation** (Must be completed if requesting Abuse & Molestation coverage or if there is overnight exposure.)

- Do you do criminal background investigations on all those involved with children?  Yes  No
- Do you have written procedures along with formal training for dealing with sexual abuse?  Yes  No
- Are there written procedures prohibiting 1:1 exposure between youth and adult?  Yes  No
- Do you have a plan of supervision that monitors staff in day-to-day relationships with clients, both on and off premises?  Yes  No
- Has your organization ever had an incident which resulted in an allegation of sexual abuse?  Yes  No  
 If yes, please describe. \_\_\_\_\_

- Was a claim made against the organization?  Yes  No
- Was the case settled?  Yes  No
- Was the case taken to trial?  Yes  No
- How much money was paid in damages to the victim \$ \_\_\_\_\_

6. How long do you maintain copies of all documentation (i.e. employment applications, background investigations, MVR's)? \_\_\_\_\_ (recommend at least 7 years for claim purposes)

**Section D: Directors and Officers**

- What is the Named Insured's tax-exempt status under the US Internal Revenue Service Code? \_\_\_\_\_
- Describe the Named Insured's nature of operations: \_\_\_\_\_

3. Provide the following financial information with respect to the Named Insured:

Total Assets (000): \$ \_\_\_\_\_ Fund Balance (net assets) (000): \$ \_\_\_\_\_ As of Fiscal Year End: Date: \_\_\_\_\_

4. Number of Employees for Current Year:

Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Seasonal \_\_\_\_\_ Temporary \_\_\_\_\_ Volunteers \_\_\_\_\_

5. Does the Named Insured have any subsidiaries:  Yes  No If yes, how many? \_\_\_\_\_

6. During the last 5 years, has the Named Insured or any of the Named Insured Persons received any demands for monetary or non-monetary relief, been involved in, or had any knowledge of any civil or criminal action, administrative or arbitration proceedings?  Yes  No

7. Is any Named Insured aware of any fact, circumstance or situation involving any Insureds that might reasonably be expected to result in a Claim?  Yes  No

**If "yes" to any part of questions 6 or 7. above, please provide full details for each allegation, even if the matter has been settled or otherwise resolved by providing the following information for each allegation by attachment:**

- (a.) Date Claim first made
- (b.) Claimant's name
- (c.) Allegation
- (d.) Current Status
- (e.) Demand Amount
- (f.) Settlement (indemnity) or Reserve Amount
- (g.) Attorney's fees

**Section E - Underwriting Information (complete if requesting General Liability)**

Do you require all event participants and volunteers to sign waivers?  Yes  No

Do you have a written contract in place with all persons or entities you contract with?  Yes  No

a) Do these contracts contain a harmless agreement whereby you the Named insured do NOT assume liability of any other person(s) or entities?  Yes  No

Do you require those you contract with to name you as an Additional Insured on their liability insurance and provide evidence of doing so?  Yes  No

**Are you contractually obligated to name any organization as an additional insured?**  Yes  No

If yes complete the following if requesting General Liability:

Additional Insured Name\*                      Complete Address                      Relationship to you (examples below)\*\*

\*Additional Insured Certificates – Each additional Insured Certificate is \$35.00 (non-commissionable).

\*\*Relationship Examples: Owners/Lessors of Premises, State or Governmental Agency or Subdivision or Political Subdivision, Lessor of Leased Equipment, Mortgagee, Assignee or Receiver, Sponsor, Co-promoters.

Do you currently have or have you had Accident Medical Coverage and/or General Liability?  Yes  No

a. If yes, please provide a copy of your current policy's schedule page.

b. If yes, please provide 3 years loss experience.

Applicant's Statement and Declarations

The applicant declares to the best of his / her knowledge the information contained in this application and all supplements attached to be true and that no material facts have been suppressed or misstated. The applicant further understands that any false or fraudulent statements or misrepresentations could result in termination or voidance of any insurance contract issued from the information stated herein.

**Authorized Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Title** \_\_\_\_\_

**All above information requested is required for policy issuance. The licensed agent is required to complete the section below. Policies cannot be issued without all the required information being completed.**

**Local/Regional Licensed Agency**

Agency Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Agent Name (Printed): \_\_\_\_\_ Agent Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Licensed Agent)

Email Address: \_\_\_\_\_ Proposal Number: \_\_\_\_\_

## **FRAUD NOTICE STATEMENTS**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS (\$5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).**

**APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV:** ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

**APPLICABLE IN COLORADO:** IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

**APPLICABLE IN FLORIDA AND OKLAHOMA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

**APPLICABLE IN KANSAS:** ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

**APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.