Amateur Sports Adult Soccer Teams, Leagues & Associations Supplemental Request Form

This supplement is valid for effective dates from 3/1/17 through 2/28/18

Please retain a copy of this form for your records.

GENERAL INFORMATION

Named insured (as it appears on your certificate of insurance): _____

Policy number (as it appears on your certificate of insurance): _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Contact name: _____ Phone: (_____) _____

Cell: (_____) _____ Fax: (_____) _____

E-mail: _____ Website: _____

EXPOSURE INFORMATION

Notes:

- You must submit this request form prior to the effective date needed
- Coverage will be made effective the day after this request form and payment are received, or on a later date that you may specify
- All participants are required to be reported. TBD numbers cannot be accepted
- A current and complete roster with names and ages of all participants is required to bind coverage
- All participants must sign waivers
- You must choose the same coverage option that is currently bound and in effect
- Should you have $1,000,000 of Sexual Abuse or Sexual Molestation Liability coverage in place with us, you will need to rate for this additional exposure with any increments you may add below on the next page.

Check one:

❍ Adding additional participants

Effective date needed: _____/_____/_____

Coverage Options	Rates	
Option 1 $ 1,000,000 Commercial General Liability $ 1,000,000 Participant Legal Liability $ 10,000 Medical Payments for Participants with $1,000 corridor deductible	$ 34.24	**w/ Brain Injury Excluded** $ 33.00
Option 2 $ 1,000,000 Commercial General Liability $ 500,000 Participant Legal Liability EXCLUDED Medical Payments for Participants	$ 7.10	**w/ Brain Injury Excluded** $ 5.91
Option 3 $ 1,000,000 Commercial General Liability EXCLUDED Participant Legal Liability EXCLUDED Medical Payments for Participants	$ 5.91 per participant	

Coverage Option (1-3)	Number of Players Age 18 and Over	+	Number of Players Age 16 to 17	=	Total Number of Players	X	Rate	=	Program Premium Due
		+		=		X		=	$

Ascension Benefits & Insurance Solutions • P.O. Box 25936 • Overland Park, KS 66225 • 1-800-955-1991
E-mail = programs@ascensionins.com • Fax 1-913-327-0201 • www.ascensionins.com/programs

EXPOSURE INFORMATION CONTINUED

Sexual Abuse or Sexual Molestation Liability (optional coverage)

Check one

❍ I currently have Sexual Abuse or Sexual Molestation Liability Coverage in place and need to add the additional participants/parties reported on the prior page to my coverage.

❍ I would like to add this coverage to my policy.

*** Note:** If you would like to add this coverage to your policy mid-term, please contact us for additional information on the proper form to complete for review and approval.

CGL Program Option Purchased (check/calculate only one)	Rate	X	Total # of Players/Participants	=	Sexual Abuse or Sexual Molestation Liability Premium Due
Option 1	$ 1.23	X		=	$_____
Option 2	$ 1.18	X			
Option 3	$ .99	X			
Other:_____	$	X			

PAYMENT DUE

Program Premium	$
Sexual Abuse or Sexual Molestation Liability Premium	$
Total Premium Due (add lines above)	**$**

OFFICE USE ONLY

Rec:_____/_____/_____ Policy #:_____ Cert #:_____ Insured #:_____

Opt:_____ Premium: $_____ Eff/Exp:_____/_____/_____ to _____/_____/_____

Comments:_____

Opt Form: 2026 2011 2404 8016 8018 876 Delivery: M F E Date: _____/_____/_____

CERTIFICATE REQUESTS

Complete this section to request a certificate. Provide separate requests for each additional certificate needed.

Date needed by: _____/_____/_____

Check the type of certificate you are requesting: ❍ Additional insured ❍ Evidence of coverage

Certificate holder information:

Entity name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Relationship to named insured: ❍ Owner/lessor of premises ❍ Sponsor ❍ Co-promoter

❍ Other: _____

Other than being named on the certificate as an additional insured or certificate holder, does the person or organization require any special wording or endorsements? ❍ Yes ❍ No

If yes, check all that apply ***(Check your request carefully before submitting. The most common delay in certificate processing is caused by providing a partial or incorrect name and/or instructions)***.

❍ Form CG2026 ❍ Primary endorsement ❍ Waiver of subrogation

❍ Other (please explain): _____

If applicable:

RE: Date(s) of event/activity: _____ / _____ / _____ to _____ / _____ / _____

Hours of event/activity: _____A.M./P.M. to _____A.M./P.M.

Type of event/activity: _____

Name of event/activity: _____

Location of event/activity: _____

MAILING INSTRUCTIONS

Submit completed supplemental form, with payment, to us.

- E-mail programs@ascensionins.com
- Fax 1-913-327-0201
- Mail Ascension Benefits and Insurance Solutions
  P.O. Box 25936
  Overland Park, KS 66225

PAYMENT INFORMATION

100% of the premium and a ROSTER are due upon receipt of this supplemental.

❍ **Check:** Please make check payable to Ascension Benefits & Insurance Solutions.

Enclosed is check #_____ for $_____

❍ **Credit Card:** If you are making your payment by credit/debit card, please complete the following:

❍ VISA ❍ MASTERCARD ❍ AMERICAN EXPRESS

Card number:_____

CSC # (card security) code:_____ Expiration date:_____

I authorize Ascension Benefits & Insurance Solutions to charge my payment to my credit card in the amount of $_____

Print name (as on card): _____

Cardholder signature: _____