



# Activity and Social Clubs Supplemental Request Form

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 members/participants are required to be reported. TBD numbers cannot be accepted.
- A roster may be requested as verification
- For limits above \$2,000,000, please contact us for a quote.
- 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:**

Adding additional members/participants

Effective date needed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Options	Option 1 \$1,000,000 CGL \$25,000 Med Pay	Option 2 \$2,000,000 CGL \$25,000 Med Pay
<b>Rates</b> (per member/participant)	\$ 3.09	\$ 4.12
<b>Minimum Premiums</b>	\$ 300.00	\$ 375.00

Activity/Operation	Coverage Option	Number of Members/Participants	X	Rate	=	Premium
			X	\$	=	\$
			X	\$	=	\$
			X	\$	=	\$
<b>Program Premium Due</b> (add all lines above)						<b>\$</b>

**Ascension Benefits & Insurance Solutions • P.O. Box 25936 • Overland Park, KS 66225 • 1-800-955-1991**

**E-mail = [programs@ascensionins.com](mailto:programs@ascensionins.com) • Fax 1-913-327-0201 • [www.ascensionins.com/programs](http://www.ascensionins.com/programs)**

Ascension Benefits & Insurance Solutions conducts business as Ascension Benefits and Insurance Solutions; in AK, AZ, CA, DC, HI, KY, LA, MA, MT, NE, NV, NH, OK, SC, SD and WV as Ascension Benefits & Insurance Solutions Sports and Recreation; or in ND as Ascension Benefits Brokerage & Insurance Solutions; or in NY as Ascension Benefits Brokerage & Insurance Solutions Sports & Recreation. CA #0334819, TX #1657333



CERTIFICATE REQUESTS

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

Note: Additional insureds are not automatically provided/issued per previous policy terms. You will need to request Additional Insureds that are needed for this policy term below.

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:

For Specific event: 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 & Insurance Solutions  
P.O. Box 25936  
Overland Park, KS 66225

PAYMENT INFORMATION

**100% of the premium is 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:** \_\_\_\_\_