



Youth Camp and Clinic Supplemental Request Form

For Adding Additional Camp and/or Clinic Session Dates

This supplemental is valid for effective dates from 3/1/24 through 2/28/25

Please retain a copy of this form for your records.

GENERAL INFORMATION

Named insured (as it appears on your Member Certificate): _____

Policy number (as it appears on your Member Certificate): _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Contact name: _____ Phone: (____) _____

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

E-mail: _____ Website: _____

EXPOSURE INFORMATION

Please note:

- You must submit this request form prior to the start of your camp and/or clinic along with payment. Coverage cannot be bound without the proper payment and completed and approved supplemental.
- You must provide the actual or maximum amount of expected campers. TBD numbers can not be accepted.
- Changes to numbers reported, must be reported in writing on or before the start of the camp and/or clinic session.
- Cancellations must be reported in writing on or before the start of the camp and/or clinic session.

1. Do any of your camps include any of the following sports? Yes No

If yes, please check those that apply and answer questions a. and b.

<input type="radio"/> Cheerleading	<input type="radio"/> Gymnastics	<input type="radio"/> Roller hockey (quad)
<input type="radio"/> Deck/floor/street hockey	<input type="radio"/> Ice Hockey	<input type="radio"/> Soccer
<input type="radio"/> Field hockey	<input type="radio"/> Inline Hockey	<input type="radio"/> Water hockey
<input type="radio"/> Football	<input type="radio"/> Lacrosse	<input type="radio"/> Wrestling

a. Do you have concussion management protocols/guidelines that are consistently enforced and includes communication (in written or electronic form) of education materials to participants, parents and coaches about the nature of risk of concussions including but not limited to information such as focusing on prevention and preparedness to keep athletes safe; understanding concussions and potential consequences of the injury; recognizing concussion symptoms and how to respond; and learning about steps for returning to play after suspected concussion? Yes No

b. If you suspect an athlete has a concussion, do you have an action plan that includes:

- Immediately removing the athlete from play or practice Yes No
- Keeping the athlete out of play or practice until they provide written clearance from a licensed physician Yes No
- Confirming sports liability waivers (informed consent) from parents and/or players are secured Yes No

K&K Insurance Group, Inc. • P.O. Box 2338 • Fort Wayne, IN 46801-2338 • 1-800-426-2889 • Fax 1-260-459-5105

www.kandkinsurance.com

K&K Insurance Group, Inc. is a licensed insurance producer in all states (TX license #13924); operating in CA, NY and MI as K&K Insurance Agency (CA license #0334819)

CAMP RATES

Use these rates to figure out your camp premiums on the next page

CLASS 1 RATES

Type of Camp Sessions	Option 1 \$1,000,000 CGL & \$25,000 Med Pay to Part.	Option 2 \$2,000,000 CGL & \$250,000 Med Pay to Part.	Option 3 \$3,000,000 CGL & \$250,000 Med Pay to Part.	Option 4 \$4,000,000 CGL & \$250,000 Med Pay to Part.	Option 5 \$5,000,000 CGL & \$250,000 Med Pay to Part.
Daily (no overnight sessions) • 2 consecutive days or less; OR • Multiple non-consecutive days	\$1.45	\$1.97	\$2.16	\$2.27	\$2.35
Weekly (no overnight sessions) 3–7 consecutive days	\$4.33	\$5.99	\$6.55	\$6.89	\$7.13
Overnight/Resident • 1–7 consecutive days NOTE: Adult-accompanied camps are not eligible for this option	\$5.75	\$7.95	\$8.69	\$9.13	\$9.46

CLASS 2 RATES

Type of Camp Sessions	Option 1 \$ 1,000,000 CGL & \$25,000 Med Pay to Part.	Option 2 \$2,000,000 CGL & \$250,000 Med Pay to Part.	Option 3 \$3,000,000 CGL & \$250,000 Med Pay to Part.	Option 4 \$4,000,000 CGL & \$250,000 Med Pay to Part.	Option 5 \$5,000,000 CGL & \$250,000 Med Pay to Part.
Daily (no overnight sessions) • 2 consecutive days or less; OR • Multiple non-consecutive days	\$1.60	\$2.20	\$2.42	\$2.55	\$2.65
Weekly (no overnight sessions) 3–7 consecutive days	\$4.78	\$6.66	\$7.34	\$7.74	\$8.04
Overnight/Resident • 1–7 consecutive days NOTE: Adult-accompanied camps are not eligible for this option	\$6.34	\$8.83	\$9.72	\$10.25	\$10.65

Note: Class 2 rates include Limited Neurodegenerative Injury Coverage to Specified Players for Sports or Athletic Activities for those sports with this limitation. If you did not purchase this coverage, adjustments will be made at the time of binding.

SEXUAL MISCONDUCT LIABILITY RATES

(use only if you were approved and purchased this coverage at the time of your original binding)

Daily Rate	Weekly Rate	Overnight Resident Rate
\$0.15	\$0.45	\$0.59

CAMP PREMIUM CALCULATIONS

IMPORTANT INFORMATION:

1. Please list each camp session individually. Do not combine a period of camp dates. Should you have more than 3, please provide additional copies of this page.
2. Coverage only applies to those camp sessions specifically reported and approved, before the camp starts.
3. The same limit option must be used for all camps.
4. If multiple sports are in a single camp, the highest sport class applies for that camp.

CAMP/SESSION #1

Name of camp: _____

Type of camp (list all the sport types and activities): _____

Dates of the camp: ____/____/____ to ____/____/____ Hours of operation: ____ A.M./P.M. to ____ A.M./P.M.

Camp days (circle all that apply): Mon Tues Wed Thurs Fri Sat Sun

Camp location(s): _____

of youth campers/participants (below age 19): _____ # of adult accompanying campers/participants: _____

Does your current policy include Sexual Misconduct Liability Coverage? Yes No

If yes, make sure to include rating below. If no, do not include sexual misconduct rate

Coverage Option	Daily or Weekly Rate	+	Sexual Misconduct Rate <small>(only if yes is checked above)</small>	=	Total Rate	x	# of Days or Weeks	x	# of Campers <small>(add youth + accompanying adult)</small>	=	Premium
	\$	+	\$	=	\$	x		x		=	\$

CAMP/SESSION #2

Name of camp: _____

Type of camp (list all the sport types and activities): _____

Dates of the camp: ____/____/____ to ____/____/____ Hours of operation: ____ A.M./P.M. to ____ A.M./P.M.

Camp days (circle all that apply): Mon Tues Wed Thurs Fri Sat Sun

Camp location(s): _____

of youth campers/participants (below age 19): _____ # of adult accompanying campers/participants: _____

Does your current policy include Sexual Misconduct Liability Coverage? Yes No

If yes, make sure to include rating below. If no, do not include sexual misconduct rate

Coverage Option	Daily or Weekly Rate	+	Sexual Misconduct Rate <small>(only if yes is checked above)</small>	=	Total Rate	x	# of Days or Weeks	x	# of Campers <small>(add youth + accompanying adult)</small>	=	Premium
	\$	+	\$	=	\$	x		x		=	\$

CAMP/SESSION #3

Name of camp: _____

Type of camp (list all the sport types and activities): _____

Dates of the camp: ____/____/____ to ____/____/____ Hours of operation: ____ A.M./P.M. to ____ A.M./P.M.

Camp days (circle all that apply): Mon Tues Wed Thurs Fri Sat Sun

Camp location(s): _____

of youth campers/participants (below age 19): _____ # of adult accompanying campers/participants: _____

Does your current policy include Sexual Misconduct Liability Coverage? Yes No

If yes, make sure to include rating below. If no, do not include sexual misconduct rate

Coverage Option	Daily or Weekly Rate	+	Sexual Misconduct Rate <small>(only if yes is checked above)</small>	=	Total Rate	x	# of Days or Weeks	x	# of Campers <small>(add youth + accompanying adult)</small>	=	Premium
	\$	+	\$	=	\$	x		x		=	\$

Complete this section if you require additional certificates listing a facility, property owner or similar third-party as an additional insured on your policy. Provide a separate request for each additional certificate needed.

CERTIFICATE REQUEST #1

Note: Please request all additional insureds needed for this policy term. Additional insureds from the expiring policy term will not be automatically renewed.

- 1. Camp #: _____
 - 2. When is this certificate needed? : ____/____/____
 - 3. What is the additional insured's relationship to you?
 - Owner/manager/lessor of premises (facility or venue) Sponsor Co-promoter
 - Other (please identify/explain): _____
- NOTE: The certificate holder will automatically be an Additional Insured for an Owner/manager/lessor, Sponsor or Co-Promoter relationship
- 4. Certificate holder/additional insured name: _____

 Mailing address: _____
 City: _____ State: _____ Zip: _____
 - 5. Does the certificate holder/additional insured require any special wording or endorsements? Yes No
 If yes, check all that apply: CG2026 Primary Waiver of subrogation
 Other (please explain): _____

NOTE: If you are not sure, please attach a copy of the insurance requirements/instructions you've received.

The most common delay in certificate processing is caused by providing partial or incorrect name and/or instructions. Please check your request carefully before submitting.

CERTIFICATE REQUEST #2

- 1. Camp #: _____
 - 2. When is this certificate needed? : ____/____/____
 - 3. What is the additional insured's relationship to you?
 - Owner/manager/lessor of premises (facility or venue) Sponsor Co-promoter
 - Other (please identify/explain): _____
- NOTE: The certificate holder will automatically be an Additional Insured for an Owner/manager/lessor, Sponsor or Co-Promoter relationship
- 4. Certificate holder/additional insured name: _____

 Mailing address: _____
 City: _____ State: _____ Zip: _____
 - 5. Does the certificate holder/additional insured require any special wording or endorsements? Yes No
 If yes, check all that apply: CG2026 Primary Waiver of subrogation
 Other (please explain): _____

NOTE: If you are not sure, please attach a copy of the insurance requirements/instructions you've received.

The most common delay in certificate processing is caused by providing partial or incorrect name and/or instructions. Please check your request carefully before submitting.

PAYMENT OPTIONS

Applicant business name: _____ Effective date: _____

PAY BY ACH (Bank Account): THIS OPTION IS ONLY AVAILABLE FOR PURCHASES MADE 15 DAYS OR MORE PRIOR TO THE EFFECTIVE DATE

- **E-mail** info@campinsurance-kk.com
or
- **Fax** 1-260-459-5105

I (we) authorize K&K Insurance Group to initiate a single electronic debit from the account shown below and have attached a voided copy of the check:

Name on Bank Account: _____ Bank Name: _____

Draft Amount : \$ _____ Checking, or Savings

Bank Routing Number* _____ Bank Account Number* _____

*See below for an explanation of where to locate these two sets of numbers on your bank check.

_____ Date: _____

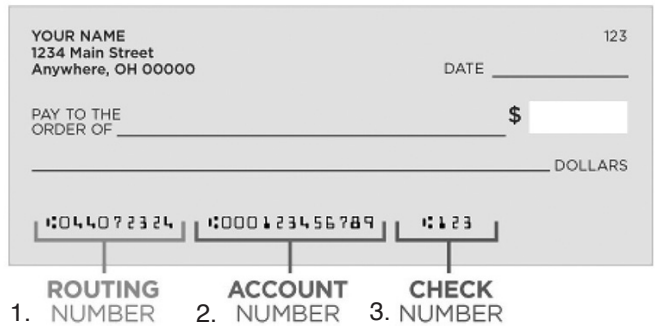
Authorized Signature(s) - (Not required if authorization by phone by K&K)

_____ Date: _____

Authorized Signature(s) - (Not required if authorization by phone by K&K)

EXPLANATION OF CHECK NUMBERS

1. Bank Routing Number - This is a nine digit number separated by a bar and a colon |: 123456789 |:
2. Account Number - This number may appear as the second, first or third series of numbers. Please read carefully.
3. Check Number - Matches number in the upper right corner of check. NOT REQUIRED FOR ACH.



PAY BY CREDIT CARD:

- **Fax only** 1-260-459-5105
- VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Card number: _____

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

I authorize K&K Insurance Group, Inc. to charge my payment to my credit card in the amount of \$ _____

Print name (as on card): _____

Cardholder signature: _____

Cardholder phone number: (____) _____

FATCA Notice: Please go to Aon.com/FATCA to obtain appropriate W-9.