Coaches' Choice

RPG DIRECTORS' & OFFICERS' LIABILITY

including Employment Practices Liability for Not-for-Profit Organizations (Claims-made Coverage)
Insurance Program and Application

This brochure is valid for effective dates from 3/1/25 through 2/28/26

PROGRAM DESCRIPTION

This program provides important protection to eligible organizations for claims arising out of allegations of errors, omissions or wrongful acts committed by its directors, officers, employees or volunteers. This coverage will respond to allegations of discrimination against a third party, acts beyond granted authority, failure to deliver services, wrongful dismissal, and wrongful employment practices. In addition, coverage provides medical payments for a bodily injury loss caused by an accident that takes place during activities that are sponsored by your business for the directors and officers of the named insured.

Defense costs are paid in addition to the limit of liability and coverage is provided on a claims-made basis, applying only to claims first made during the coverage period.

Coverage is provided by a carrier rated A (Excellent) by A.M. Best Company.

INELIGIBLE OPERATIONS

Organizations that do not meet the eligibility criteria listed in this brochure are not eligible for this program as well as:

- Booster clubs (those supporting/funding interscholastic/intercollegiate athletic programs)
- Condo Associations, homeowner associations, or similar organizations
- Governmental entities or organizations

(**Note:** This is not a complete list of ineligibles)

EASY WAYS TO ENROLL FOR COVERAGE

WEB For information and applications, visit us on-line at **www.mycare26.com/specialty-programs**

OR

Submit this enrollment form, with payment, to us.

FAX 1-913-754-5617

MAIL Academic HealthPlans, Inc.
PO Box 81315
Cleveland, OH 44181

QUESTIONS Call 1-**913-754-5617**

FOR SERVICE REQUESTS ONLY

E-MAIL
recsportsandmore@recsportsandmore.ahpcare.com

ELIGIBLE OPERATIONS

Organizations that meet all of the following criteria are eligible to submit an enrollment form for coverage under this program:

1. The organization has tax exempt status as a not-for-profit organization.
2. The annual gross revenue of the organization from all sources is $3,000,000 or less.
3. The organization has obtained general liability coverage through a supporting Sports, Leisure and Entertainment Risk Purchasing Group Insurance Program offered by us.

COVERAGE AND LIMITS

This program provides two limit options to choose from.

Option A	
Maximum Aggregate Limit of Liability	$ 1,000,000
Retention (each claim)	$ 1,000
Medical Payments for Directors' & Officers' (per director or officer)*	$ 10,000

Premium (based on annual gross revenue)

Annual Revenue	All Applicants (except for Hawaii)	Hawaii Applicants Only
$ 0 - $1,000,000	$ 657.00	$ 647.00
$1,000,001 - $2,000,000	$ 1,129.00	$ 1,116.00
$2,000,001 - $3,000,000	$ 1,601.00	$ 1,584.00
$3,000,001 or higher	Refer to us	Refer to us

Option B	
Maximum Aggregate Limit of Liability	$ 2,000,000
Retention (each claim)	$ 1,000
Medical Payments for Directors' & Officers' (per director or officer)*	$ 10,000

Premium (based on annual gross revenue)

Annual Revenue	All Applicants (except for Hawaii)	Hawaii Applicants Only
$ 0 - $1,000,000	$ 998.00	$ 982.00
$1,000,001 - $2,000,000	$ 1,733.00	$ 1,584.00
$2,000,001 - $3,000,000	$ 2,441.00	$ 2,343.00
$3,000,001 or higher	Refer to us	Refer to us

* Not available for FL applicants

EXCLUSIONS

The following represent only some of the exclusions contained in this policy.

- Advertising injury
- Bodily injury
- ERISA of 1974
- Failure to maintain proper insurance
- Fair Labor Standards Act (except the Equal Pay Act)
- Fungi
- Nuclear
- Personal injury
- Pollutants
- Property damage
- The Consolidated Omnibus Budget Reconciliation Act of 1985
- The Federal False Claims Act
- The National Labor Relations Act
- The Occupational Safety and Health Act
- The Racketeer influenced and Corrupt Organizations Act
- The Worker Adjustment and Retraining Notification Act
- Written or Express Contract or Agreement
- Wrongful death

COVERAGE INFORMATION

The following are several coverage explanations related to a claims-made policy that should be considered.

Prior Acts

If a claims made policy contains a retroactive date, that policy provides no coverage for claims arising out of incidents, occurrences, or alleged wrongful acts which took place prior to that retroactive date.

Claims Made During Policy Period

This policy covers only claims actually made or incidents reported against the insured while policy remains in effect, or any applicable extended reporting period. All coverage under the policy ceases upon the termination date, except for the automatic extended reporting period coverage, unless the insured purchases additional extended reporting period coverage.

Extended Reporting Period

The automatic extended reporting period is sixty (60) days from the termination or expiration date of the policy. The additional extended reporting period, if purchased, may be up to three (3) years for non-profit policies. If this extended reporting period is not purchased and the subsequent policy does not provide full prior acts coverage or is an occurrence policy, there may be gaps in coverage.

Claims-made Policy Maturity

When the retroactive date on a claims made policy is concurrent with the effective date of the policy or less than five years prior to the effective date, there is considered to be a reduced level of exposure in relation to an occurrence policy. For this reason, claims made rates are comparatively lower than occurrence rates. As the claims made relationship matures, the insured can expect substantial annual premium increases independent of overall rate level increases. If, however, the retroactive date on a claims made policy is more than five years prior to the effective date of the policy, that claims made relationship is considered mature and rate levels will not increase for this reason.

FREQUENTLY ASKED QUESTIONS

1. **Does D&O liability cover allegations against the board for sexual abuse or sexual molestation?**

   This type of allegation would be covered under the abuse, molestation, or exploitation defense reimbursement coverage which is available for purchase as an optional coverage with a commercial general liability policy through a supporting Sports, Leisure and Entertainment Risk Purchasing Group offered by us.

2. **Does D&O liability provide coverage if a participant is injured during a covered activity?**

   No, this would be covered under the medical payments for participants coverage, if eligible, that is provided with a commercial general liability policy through a supporting Sports, Leisure and Entertainment Risk Purchasing Group Insurance Program offered by us.

   This program only offers medical payments coverage to the directors and officers of the insured, if injured during their scope of duties on behalf of the insured.

3. **Can any board member complete and sign the D&O liability application?**

   The carrier requires that the application for D&O liability coverage be completed and signed by either the President, Executive Director or the Treasurer of the board.

4. **Will I receive a policy after I submit the enrollment form?**

   If you are a new account, you will receive a copy of the policy. Renewal accounts will only receive a certificate of insurance evidencing coverage.

This brochure is for illustrative purposes only, and is not a contract of insurance. You must refer to the actual policy for complete information regarding coverage terms, conditions, and exclusions. A copy of the policy is available upon request.

HOW TO OBTAIN COVERAGE

To avoid processing delays, please:

1. **Complete all sections and pages (print legibly)**
2. **Sign and date where required**
3. **Remit pages 3 - 5 along with application pages 1 - 4 (MAML 025) and payment**

Desired Effective Date: Check One.

❍ Start my coverage on the date after my application and payment are received

❍ Start my coverage on this date: _____/_____/_____

Note: Coverage will not be made effective prior to the date that the application and payment are received and approved by us.

Additonal Information on Obtaining Coverage

You will be notified by us if, for any reason, your submission to this insurance program is declined or determined to be ineligible for coverage and your premium payment will be returned or refunded. Incomplete applications will be declined and returned. If your application is accepted, coverage documents will be issued by us. Coverage will become effective the day your application and premium payment are received and approved by us, or on a later date that you may specify. Coverage is provided on an annual basis and is 100% fully earned and non-refundable/non-transferable once coverage begins (may vary by state).

Completion of this enrollment form confirms your desire to obtain insurance through the Sports, Leisure and Entertainment Risk Purchasing Group, a group formed and operating pursuant to the Liability Risk Retention Act of 1986 (15 USC 3901 et seq.). A risk purchasing group (RPG) provides group purchasing power for similar risks resulting in potential advantageous coverage terms, and competitive rates for favorable group loss experience. An RPG administration fee may be charged. The submission of this enrollment form and/or the acceptance of payment does not guarantee coverage. Certain operations are not eligible for coverage by this program. We reserve the right to decline any request for coverage.

PROGRAM CALCULATION

Select on option:

Premium (based on annual gross revenue)	**Option A $1,000,000 Limit**		**Option B $2,000,000 Limit**	
	Applicant Rates (except for Hawaii)	**Hawaii Applicant Rates**	**Applicant Rates (except for Hawaii)**	**Hawaii Applicant Rates**
$ 0 - $ 1,000,000	❍ $ 657.00	❍ $ 647.00	❍ $ 998.00	❍ $ 982.00
$ 1,000,001 - $ 2,000,000	❍ $ 1,129.00	❍ $ 1,116.00	❍ $ 1,733.00	❍ $ 1,584.00
$ 2,000,001 - $ 3,000,000	❍ $ 1,601.00	❍ $ 1,584.00	❍ $ 2,441.00	❍ $ 2,343.00
$ 3,000,001 or higher	Refer to company	Refer to company	Refer to company	Refer to company

PREMIUMS ARE 100% FULLY EARNED AND NON-REFUNDABLE/NON-TRANSFERRABLE ONCE COVERAGE BEGINS. COVERAGE IS CONTINGENT UPON RECEIPT OF PAYMENT AND A FULLY COMPLETED ENROLLMENT FORM. NO COVERAGE WILL BE DEEMED IN EFFECT UNTIL THE ACCURATE PAYMENT IS RECEIVED BY THE COMPANY OR THEIR REPRESENTATIVE. CANCELLATONS/CHANGES CAN ONLY BE MADE BY THE NAMED INSURED.

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E-mail = recsportsandmore@recsportsandmore.ahpcare.com • Fax 1-913-754-5617
www.mycare26.com/specialty-programs
CA # 0H64806, TX # 1554208, FL # L074590

PLEASE READ AND COMPLETE THE BELOW

(if you do not wish to receive documents via email and prefer another method of document delivery)

Consent for Electronic Transactions

The Electronic Signatures in Global and National Commerce Act provides that a signature, contract or other record may not be denied legal effect, validity or enforceability solely because it is in electronic form or because an electronic signature was used in a transaction.

As part of your participation in this program you will receive all documentation, including but not limited to, the insurance quotes, policies, certificates, endorsements, and invoices (if applicable), by electronic means. If permitted by your state, you may also receive conditional renewal notices, cancellation, or non-renewal notices via electronic delivery.

To obtain, download, and view all policy documentation electronically you must have the following hardware or software in place.

- A personal computer capable of receiving, accessing, and displaying or printing or storing communications and documents received in an electronic form.
- Adobe PDF Reader version
- System requirements: OC: Windows 7 or higher, Internet Explorer v11 or higher, Firefox v45.7 or higher, Chrome v40 or higher; OS: Mac OS x 10.9 or higher, Safari 9.0 or higher, Firefox v45.7 or higher, Chrome v40 or higher.

By agreeing to receive documents electronically, you are affirming that your computer system meets the hardware and software requirements for receiving all related documents. If documents are provided through a website or portal, you should download and store all such documents. For persons who receive electronic documents via email, these documents will be delivered to the email address on file. Upon receipt of your emailed documentation please save a copy on your own device.

You agree to notify us promptly if your mailing address, e-mail address or other delivery information changes by calling 1-913-754-5617 or mailing us at Academic HealthPlans, Inc., PO Box 81315, Cleveland, OH 44181.

We will endeavor to provide a notice to you in the event of any changes regarding hardware or software requirements necessary to receive documents and other related documents electronically. However, it is your duty to notify us if you are unable to access the documentation made electronically available to you.

We may at our sole discretion discontinue availability of electronic delivery at any time, without further notice to you. At any time, you may request a paper copy of your documents in lieu of electronic delivery. You may withdraw your consent to receive electronic documentation by sending a request in writing to us at Academic HealthPlans, Inc., PO Box 81315, Cleveland, OH 44181. Until receipt of such withdrawal, you will continue to receive all documentation electronically.

This consent is voluntary, by accepting, you signify that you consent to these terms of electronic document delivery via email or other electronic media in connection with your insurance documents, whether such delivery is made on its own behalf and/or on behalf of an organization or other third party. You further represent and warrant that if consenting on behalf of an organization or third party, you have the requisite authority to provide such consent, and that you and the organization have the requisite hardware and software to receive and acknowledge receipt of electronically delivered Documents.

After this enrollment form is approved, you will receive a certificate of insurance showing evidence that coverage has been bound. When submitted through an insurance agent or broker, this coverage document will only be delivered to them. Additional certificate requests will be issued to the same person. Providing an email address in this application will be deemed consent to us to deliver documents and communication to you electronically.

I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY. SUCH ELECTRONIC MAILING OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES.

If you DO NOT want to be emailed, please check here and select your preferred method of document delivery. ❍

❍ Fax to: _____ Attn: _____

❍ Mail to: _____ Attn: _____

ATTENTION: AGENTS

AGENTS: YOU MUST COMPLETE THE AGENT WARRANTY SECTION BELOW. Applications cannot be accepted unless this section is completed.

Agency name:_____ Agent/contact name: _____

Agency complete mailing address: _____

Agency telephone: (_____) _____ Agency fax: (_____) _____

Agent/contact e-mail address: _____ Tax I.D. _____

I represent and warrant as an insurance producer that I currently maintain, and will maintain, all individual, corporate or agency licenses or permits to conduct insurance business in the state coverage for this insured is being written. I further represent and warrant that I currently maintain errors and omissions insurance with a minimum limit of $1,000,000 for myself, my officers, and employees. If requested by the company, I will provide them with reasonably satisfactory evidence of all of the above mentioned items.

I understand that agents do not have authority to issue binders or a certificate of insurance on behalf of this program.

Agent signature: _____ **Date:** _____

PAYMENT

Select Payment Option

❍ ACH – this option is only available for purchases made 15 days or more prior to the effective date

Proceed to https://res.epaypolicy.com to complete the ACH payment

❍ Mail in Check – make check payable to Academic HealthPlans, Inc.

Academic HealthPlans, Inc.
PO Box 81315
Cleveland, OH 44181

❍ Credit Card - please note there will be a 3.5% fee added for credit card transactions

Proceed to https://res.epaypolicy.com to complete the credit card payment.

Markel Insurance Company

Non-Profit Directors And Officers And Organization, Employment Practices, And Third Party Discrimination Liability Application

NOTICE: THE POLICY FOR WHICH APPLICATION IS MADE APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD.

1. Full name of organization: _____

   Principal business address: _____

   Phone #: _____ Fax #: _____ Email: _____

   City: _____ State:_____ Zip Code: _____ Website: _____

   Mailing address if different from principal business address: _____

   City: _____ State: _____ Zip Code:_____

2. Contact person: _____

   Title: _____ Phone #: _____ Email: _____

3. Date established:_____ State of incorporation:_____

4. FEIN #: _____ NAICS Code: _____

5. ❍ Non-Profit ❍ For-Profit

6. If applicable, provide the number of club memberships:_____

7. Provide a description of the organization's operations and events:_____

8. Organization's financial information:

   a. Annual gross revenues for the past 12 months (include receipts from fees, fundraisers, memberships, sponsorships, ticket sales): $ _____

   b. Total Assets: $_____

   c. Total Liabilities: $_____

   If any of the above are greater than $5,000,000, submit financial statements.

9. Provide the number of volunteers and compensated employees:

   Volunteers (persons who donate their services):_____

   Full-time compensated employees (over 30 hours a week for 12 months):_____

   Part-time compensated employees (under 30 hours a week or less than 12 months):_____

10. Has any insurer cancelled, rescinded, non-renewed, or declined any similar insurance for the organization, its predecessors, subsidiaries, affiliates, or for any other person or organization proposed for this insurance in the past 5 years? (Not applicable in in Missouri) ❍ Yes ❍ No

    If yes, provide details._____

11. Insurance:

    a. Does the organization currently carry Directors And Officers And Organization and Employment Practices Liability Insurance? ❍ Yes ❍ No

    If yes, provide:

    Insurer:_____Limits Of Liability: $_____

    Effective Date:_____

    b. Does the organization currently carry General Liability Insurance? ❍ Yes ❍ No

    If yes, provide:

    Insurer:_____Limits Of Liability: $_____

    Effective Date:_____

12. Has the organization, any of its subsidiaries, or any director or officer been involved in or have knowledge of any pending or completed anti-trust, copyright, or patent litigations within the past 5 years?

❍ Yes ❍ No

If yes, provide details: _____

13. Has (have) any judgment(s), settlement(s), payment(s), claim(s), or suit(s) been made against any person(s) or organization(s) proposed for this insurance such as would fall within the scope of the proposed insurance?

For Kansas applicants: Has (have) any been within the past 3 years?

❍ Yes ❍ No

If yes, provide details:_____

14. Is (are) any person(s) or organization(s) proposed for this insurance aware of any fact, circumstance, incident, or situation which might afford grounds for any claim, suit, or notice of incident, including employment practices and third party discrimination, such as would fall within the scope of the proposed insurance?

❍ Yes ❍ No

If yes, provide details:_____

15. Have any charges been filed against the organization with the Equal Employment Opportunity Commission or state agency within the past 5 years?

❍ Yes ❍ No

If yes, provide details:_____

16. Outside Directorship:

a. Do any of the organization's directors, trustees, officers, employees, or volunteers serve in any position with a non-profit outside entity at the request of the organization?

❍ Yes ❍ No

b. If yes and coverage is requested, answer the following:

(1) Name of non-profit outside entity: _____

(2) Nature of operations of the non-profit outside entity: _____

(3) Position with the non-profit outside entity:_____

(4) Provide the insurer and limits of liability for Directors And Officers Liability Insurance carried by the non-profit outside entity:_____

(5) Has the non-profit outside entity had any judgment(s), settlement(s), payment(s), claim(s) or suit(s) in past 5 years?

For Kansas applicants: Has (have) any been within the past 3 years?

❍ Yes ❍ No

If yes, provide details. _____

Fair Credit Report Act Notice: Personal information about you, including information from a credit or other investigative report, may be collected from persons other than you in connection with this application for insurance and subsequent amendments and renewals. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization. Credit scoring information may be used to help determine either your eligibility for insurance or the premium you will be charged. We may use a third party in connection with the development of your score. You may have the right to review your personal information in our files and request correction of any inaccuracies. You may also have the right to request in writing that we consider extraordinary life circumstances in connection with the development of your credit score. These rights may be limited in some states. Please contact your agent or broker to learn how these rights may apply in your state or for instructions on how to submit a request to us for a more detailed description of your rights and our practices regarding personal information.

Fraud Warning: Any person who knowingly and with intent to defraud any Insurance Company or another person files an application for insurance or statement of claim 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 the person to criminal and civil penalties. (Not applicable in AL, AR, CO, DC, FL, KS, KY, LA, MD, ME, MN, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, VT, WA, and WV) (Insurance benefits may also be denied in LA, ME, TN, and VA.)

STATE FRAUD STATEMENTS

Applicable in AL, AR, DC, LA, MD, NM, RI, and WV
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO
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 FL and OK
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 (of the third degree)*. *Applies in FL Only.

Applicable in KS
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, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or 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 KY, NY, OH and PA
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA
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, and denial of insurance benefits. *Applies in ME Only.

Applicable in MN
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in NJ
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in VT
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE - PLEASE READ CAREFULLY

NO FACT, CIRCUMSTANCE, OR SITUATION INDICATING THE PROBABILITY OF A CLAIM OR ACTION FOR WHICH COVERAGE MAY BE AFFORDED BY THE PROPOSED INSURANCE IS NOW KNOWN BY ANY PERSON(S) OR ORGANIZATION(S) PROPOSED FOR THIS INSURANCE OTHER THAN THAT WHICH IS DISCLOSED IN THIS APPLICATION. IT IS AGREED BY ALL CONCERNED THAT IF THERE IS KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE, OR SITUATION, ANY CLAIM SUBSEQUENTLY EMANATING THEREFROM WILL BE EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSON(S) AND ORGANIZATION(S) PROPOSED FOR THIS INSURANCE DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS IN THIS APPLICATION AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE. THE INSURER AND AFFILIATES THEREOF ARE AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO PROVIDE OR THE ORGANIZATION TO PURCHASE THE INSURANCE.

THIS APPLICATION, INFORMATION SUBMITTED WITH THIS APPLICATION, AND ALL PREVIOUS APPLICATIONS AND MATERIAL CHANGES THERETO ARE CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY IF ISSUED. THE INSURER HAVE RELIED UPON THIS APPLICATION AND ALL SUCH ATTACHMENTS IN ISSUING THE POLICY.

IF THE INFORMATION IN THIS APPLICATION AND ANY ATTACHMENT MATERIALLY CHANGES BETWEEN THE DATE THIS APPLICATION IS SIGNED AND THE EFFECTIVE DATE OF THE POLICY, THE ORGANIZATION WILL PROMPTLY NOTIFY THE INSURER OR ITS AUTHORIZED REPRESENTATIVE, WHO MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION OR AGREEMENT TO BIND COVERAGE.

THE UNDERSIGNED DECLARES THAT THE PERSON(S) AND ORGANIZATION(S) PROPOSED FOR THIS INSURANCE UNDERSTAND THAT:

THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD.

REPRESENTATION

The undersigned represents to the Insurer that the person(s) and organization(s) proposed for this insurance understand and accept the notice stated above and further represents that the information contained herein is true and will be the basis of the policy and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy.

The undersigned authorizes the release of claim information from any prior insurer to the Insurer.
This application is signed by undersigned authorized agent of the organization(s) on behalf of the organization(s) and its, directors, officers, and employees.

This application must be signed by president, executive director, or treasurer acting as an authorized agent of the organization within 20 days of the proposed effective date.

_____	_____
Name of applicant	Title
_____	_____
Signature of applicant	Date

INSURANCE AGENT INFORMATION (if applicable)

Agency name: _____

Agency mailing address: _____

City: _____State:_____ Zip Code: _____

Agent contact name: _____

Agent email: _____

Agency phone #: _____ Agency fax #: _____ Agency tax id #:_____

Florida Only - Produced By (Insurance Agent Or Broker): _____

Agent License #: _____