Martial Arts Schools & Programs
Supplemental Request Form - HAWAII ONLY APPLICANTS

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

Check one: ❍ Adding additional participants to existing coverage ❍ Adding new coverage

Effective date needed: _____/_____/_____

Note:
- 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.
- 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 on the next page.
- 100% of the premium is due upon receipt of this supplemental. Payment plans are not available with supplemental requests.

If you carry limits of $3,000,000 or above, please contact us for a quote.

	Type of Activity/ Programs/Classes	Number of Participants	X	$1 Mil Rate	$2 Mil Rate	=	Premium
❍	Martial Arts Please describe:_____		X	$18.90	$24.15	=	$
❍	Dance Programs or Classes		X	$14.50	$19.15	=	$
❍	Camps/clinics		X	$14.50	$19.15	=	$
❍	Exercise and/or Yoga		X	$14.50	$19.15	=	$
❍	Exhibitions, Seminars or Demonstrations (involving guest participants)		X	$14.50	$19.15	=	$
❍	Tumbling/Gymnastic Programs or Classes (floor only) Please describe types of programs/classes offered along with age groups, level of training and apparatuses used (subject to approval):_____ _____		X	$14.50	$19.15	=	$
❍	Other (please describe) _____ Note: This is subject to approval by us		X	$14.50	$19.15	=	$
❍	Birthday/Social Parties	Number of parties _____	X	$16.50	$22.25	=	$
Program Premium Due (add all lines above)							$

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CA # 0H64806, TX # 1554208, FL # L074590

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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.

	Activity Type	Rate (per participant)	X	Total # of Participants (see prior page)	=	Premium
❍	Martial Arts	$ 2.10	X		=	$
❍	Non-registered Member Activity(s) • Dance • Camp/Clinic • Exercise and/or Yoga • Exhibitions, Seminars or Demonstrations • Tumbling (floor only) • Other	$ 1.86	X		=	$
❍	Birthday or Social Party	$ 2.30 per party	X	_____ # of parties	=	$
TOTAL Sexual Abuse or Sexual Molestation Liability Premium (add all lines above)						$

PAYMENT DUE

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

CERTIFICATE REQUESTS

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.

1. When is this certificate needed? : _____ / _____ / _____

2. 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

3. Certificate holder/additional insured name: _____
Mailing address: _____
City: _____ State: _____ Zip: _____

4. Does the certificate holder/additional insured require any special wording or endorsements? ❍ Yes ❍ No
If yes, check all that apply: ❍ CG2026 ❍ Primary/Noncontributory ❍ Waiver of subrogation
❍ Other (please explain): _____

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

If applicable:

5. For specific events: 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: _____

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

Submit a completed supplemental and payment via one of the options below.

Applicant business name: _____ Effective date:_____

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.
16201 West 95th Street, Suite 210
Lenexa, KS 66219

❍ 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