Amateur Sports Adult Soccer Teams, Leagues & Associations 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 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.

❍ 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	**w/ Limited $1,000,000 Brain Injury Coverage*** $ 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	**w/ Limited $1,000,000 Brain Injury Coverage*** $ 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	$ 4.93 per participant	

* LIMITED BRAIN INJURY - "Brain injury means concussion, chronic traumatic encephalopathy or any other injury to the brain and any symptoms, conditions, disorders and diseases, including death, resulting therefrom but only if such injury occurs as a result of specific events occurring during the policy period.

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		=	$

Relation Insurance Services - Specialty Risk, Inc. • P.O. Box 25936 • Overland Park, KS 66225 • 1-800-955-1991
E-mail = programs@relationinsurance.com • Fax 1-913-327-0201 • www.4RecSportsAndMore.com
CA #0H18178, TX #1657333

1750-Relation 1/2020

EXPOSURE INFORMATION CONT.

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)	**$**

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.

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

1. When is this certificate needed? : _____/_____/_____ This certificate is for: ❍ General Liability Coverage

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 ❍ 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

100% of the premium and ROSTER are due upon receipt of this supplemental
Submit a completed supplement and payment to:

Organization/host name: _____ Effective date: _____

PAY BY ACH (Bank Account):

- **E-mail** programs@relationinsurance.com
  or
- **Fax** 1-913-327-0201

I (we) authorize Relation Insurance Services to initiate a single electronic debit from the account shown below:

Name on Bank Account: _____ Bank Name:_____

Draft Amount : $_____ ❍ Checking, or ❍ Savings

Bank Account Routing/Transit Number*_____ Bank Account Number* _____

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

_____ Date: _____

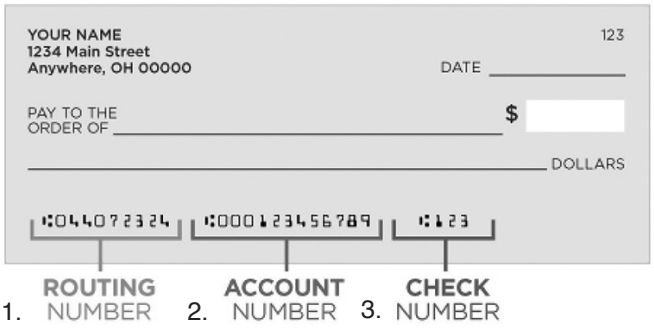
Authorized Signature(s) - (Not required if authorization by phone)

_____ Date: _____

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

EXPLANATION OF CHECK NUMBERS

1. Bank Routing/Transit Number - This is a nine digit number separated by a bar and a colon I: 123456789 I:
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 CHECK: (Payable to Relation Insurance Services)

- **Mail**

Regular Mail	Overnight Mail
Relation Insurance Services P.O. Box 25936 Overland Park, KS 66225	Relation Insurance Services 9225 Indian Creek Parkway, Suite 700 Overland Park, KS 66210

PAY BY CREDIT CARD:

- **Fax only** 1-913-327-0201

❍ VISA ❍ MASTERCARD ❍ AMERICAN EXPRESS

Card number: _____

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

I authorize Relation Insurance Services to charge my payment to my credit card in the amount of $_____

Print name (as on card):_____

Cardholder signature:_____

Cardholder phone number: (____)_____