



Amateur Sports Adult Soccer Teams, Leagues & Associations Optional Coverages Supplemental Request Form

This supplement is valid for effective dates from 3/1/20 through 2/28/21

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: _____

Please check the optional coverage(s) you are seeking:

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 by us, or on a later date that you may specify
- Coverage must follow the same commercial general liability coverage option purchased for your team, league or association for Hosted Tournament and/or Premises Liability for Sports Fields Optional Coverages
- Hosted Tournament coverage is only available if Option 1 or Option 2 is purchased
- Premiums are 100% fully earned and non-refundable upon inception
- All participants must sign a waiver

HOSTED TOURNAMENT OPTIONAL COVERAGE

Hosted tournaments are those you organize and operate that include participants who are not members of your club or team. Hosted tournaments must be 3 days or less in duration.

Event name: _____

Event date(s): ____/____/____ to ____/____/____ Event hours: _____ A.M./P.M. to _____ A.M./P.M.

Location: _____

Sport type: _____ Age group: _____ Total spectator attendance: _____

PREMIUM CALCULATION	Options	Hosted Tournament Rates/Premium Calculation per Tournament		
	Option 1 \$1,000,000 CGL Limit \$1,000,000 PLL Limit \$10,000 Med Pay with \$1,000 corridor deductible	<input type="radio"/> \$ 4.37	X _____	= \$ _____ (A) Hosted Tournament Premium (\$400.00 minimum premium applies)
	Option 2 \$1,000,000 CGL Limit \$500,000 PLL Limit Med Pay Excluded	<input type="radio"/> \$ 2.33	X _____	= \$ _____ (A) Hosted Tournament Premium (\$350.00 minimum premium applies)
	Other _____	<input type="radio"/> \$ _____	X _____	= \$ _____ (A) Hosted Tournament Premium

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

○ Sexual Abuse or Sexual Molestation Liability Coverage OR Abuse, Molestation or Harassment or Sexual Conduct Defense Cost Reimbursement

Coverage is contingent upon underwriting review and approval of the following questionnaire.

1. Does your organization currently have employees, volunteers or independent contractors? Yes No
The term "Volunteers" means someone, including parent volunteers, who exerts control over or supervises participants.
2. Have any claims, allegations or charges of abuse, molestation or sexual misconduct Yes No been made against you or your organization or anyone working on behalf of your organization?
If yes, please explain: _____
3. Are you aware of any occurrences that could lead to a claim? Yes No
If yes please explain: _____
4. Do you, your organization or sanctioning/governing body have written procedures in place regarding the prevention and mitigation of abuse, molestation or sexual misconduct? Yes No
If yes:
 - a. Do the procedures require that known or suspected abuse incidents must be reported to law enforcement? Yes No
 - b. Are written procedures provided or available to each employee, volunteer, independent contractor or sanctioning/governing body member? Yes No
 - c. Does your written plan include reasonable procedures to limit one-on-one interactions between a minor and an adult (who is not the minor's legal guardian) to those that are observable by another adult and within an interruptible distance, except under emergency circumstances? Yes No
5. Please complete the following questions regarding employee, volunteer, or independent contractor screening controls used by your organization.
 - Check here and skip the chart below if you have no employees, volunteers, or independent contractors

Please Complete All Questions <small>The term "Volunteers/Independent contractors" in the following questions means someone who exerts control over or supervises participants.</small>	Employees (Check Here if No Employees <input type="radio"/>)	Volunteers/Independent contractors (Check Here if No Volunteers/Independent contractors <input type="radio"/>)
Are employee/volunteer applications required? If yes, does the application include questions about whether the individual has ever been convicted for any crime involving physical violence or sex related offenses? If yes and applicant checks yes, do you reject the applicant?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
Are background checks provided by a third party vendor/service? If yes, do you reject an applicant with any history of physical violence or sex related offenses?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No

Please complete the following Please explain any "No" responses to questions asked in #5: _____

6. Calculate premium:

○ Option 1 – \$1,000,000 Sexual Abuse or Sexual Molestation Liability					
CGL Program Option Purchased (check/calculate only one)	Rate	X	Total # of Players/Participants	=	Premium
Option 1	\$ 1.23	X		=	\$ _____ (B) (\$150.00 minimum premium applies)
Option 2	\$ 1.18	X			
Option 3	\$.99	X			
Other: _____	\$	X			
○ Option 2 – \$100,000 Abuse, Molestation, Harassment or Sexual Conduct Defense Cost Reimbursement					\$100.00 (B)

EQUIPMENT & CONTENTS

TO AVOID A CO-INSURANCE PENALTY, YOU MUST INSURE 100% OF THE REPLACEMENT COST OF YOUR EQUIPMENT AND CONTENTS FOR ALL OF YOUR LOCATIONS.

Step 1: Fill in the values to determine your total replacement cost amount for ALL locations

Individually list any items with values over \$5,000	Value
_____	\$ _____
_____	\$ _____
_____	\$ _____

Provide values for categories below
(DO NOT include those values already shown above)

<u>Sports equipment</u> (such as balls, uniforms, pads, helmets, netting)	\$ _____
<u>Field maintenance equipment</u> (such as lawn mowers, grooming equipment)	\$ _____
<u>Concession stand equipment, excluding products</u> (such as popcorn, hot dog and soda machines)	\$ _____
<u>Portable storage units</u> (not permanent structures)	\$ _____
<u>Misc. equipment</u> - please describe _____	\$ _____

Total replacement value for all location(s) (add all lines above) \$ _____

Step 2: Complete ONLY if your replacement cost value is over \$100,000

1. Please describe the building type your equipment is stored in (e.g.: frame or fire resistive warehouse)

2. Do you have a security system in place? Yes No
 - a. If yes, please describe: _____
3. Is any other operations, besides your own, or equipment of others stored in the same facility in which you store your equipment? Yes No
 - a. If yes, please describe: _____
4. Please attach a complete inventory list with values of each item

Step 3: Calculate premium

(If total calculated premium is less than the minimum premium, the total premium due is the minimum premium)

Equipment & Contents Premium	
<input type="radio"/> My total replacement value is between \$1 - \$10,000 (\$250 deductible will apply)	
$\$.03 \times \$ \underline{\hspace{2cm}} = \$ \underline{\hspace{2cm}}$ Total Replacement Value	$\$ \underline{\hspace{2cm}} (C)$ Equipment & Contents Premium (\$100.00 minimum premium applies)
<input type="radio"/> My total replacement value is over \$10,000 (A \$1,000 deductible applies to values from \$10,001 - \$100,000 and a \$2,500 deductible applies to values over \$100,000)	
$\$.026 \times \$ \underline{\hspace{2cm}} = \$ \underline{\hspace{2cm}}$ Total Replacement Value (\$100.00 minimum premium applies)	$\$ \underline{\hspace{2cm}} (C)$ Equipment & Contents Premium

PREMISES LIABILITY FOR SPORTS FIELDS OPTIONAL COVERAGE

This coverage provides premises liability coverage for those organizations that are a not-for-profit organization and own, operate or are responsible for a sports field(s) on a 24 hour basis and do not rent, donate or lease the field(s) to other organizations.

Effective date needed: ___/___/___ to ___/___/___

Are you a not-for-profit organization? Yes No

Do you rent, donate or lease the field(s) to other organizations? Yes No

Physical address for sport field(s): _____
 Address City State Zip

Options	Premises Liability for Sports Fields Rates/Premium Calculation				
Option 1 \$1,000,000 CGL Limit	<input type="radio"/> \$ 12.71	X	_____	=	\$ _____
			Acreage		
	\$ 50.00	X	_____	=	\$ _____
			# of fields		\$ _____ (D) Premium = greater of two totals
Other _____	<input type="radio"/> \$ _____	X	_____	=	\$ _____
			Acreage		
	\$ _____	X	_____	=	\$ _____
			# of fields		\$ _____ (D) Premium = greater of two totals

Complete this section if you require additional certificates listing a facility, property owner or similar third-party 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? : ___/___/___

2. This certificate is for: Hosted Tournament Coverage Equipment & Contents/Inland Marine Coverage (if applicable)
 Premises Liability for Sports Fields

3. What is the additional insured's relationship to you? Owner/manager/lessor of premises (facility or venue)
 Sponsor Co-promoter Lessor of equipment/contents (liability) Loss Payee (equipment/contents)
 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.

6. 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: _____

7. For Loss Payee: Type of equipment (please describe): _____

Replacement cost value: _____

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.

TOTAL OPTIONAL COVERAGE PREMIUM	Hosted Tournament Premium:	\$ (A)
	Sexual Abuse/Sexual Molestation Premium: ○ \$100,000 Defense Reimbursement Only OR ○ \$1,000,000 Liability Limit	\$ (B)
	Equipment and Contents Premium	\$ (C)
	Premises Liability for Sports Fields Premium:	\$ (D)
	Total Premium Due (add all lines above)	\$

COSTS ARE 100% FULLY EARNED AND NON-REFUNDABLE/NON-TRANSFERRABLE ONCE COVERAGE BEGINS.

**COVERAGE IS CONTINGENT UPON RECEIPT OF AN
APPROVED AND COMPLETED SUPPLEMENTAL FORM AND FULL PAYMENT.**

**NO COVERAGE WILL BE DEEMED IN EFFECT UNTIL ACCURATE PAYMENT AND FULLY COMPLETED
SUPPLEMENTAL FORM ARE RECEIVED BY THE COMPANY OR REPRESENTATIVE.**

CANCELLATIONS/CHANGES CAN ONLY BE MADE BY THE NAMED INSURED.

PAYMENT OPTIONS

Submit a completed supplemental 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: _____

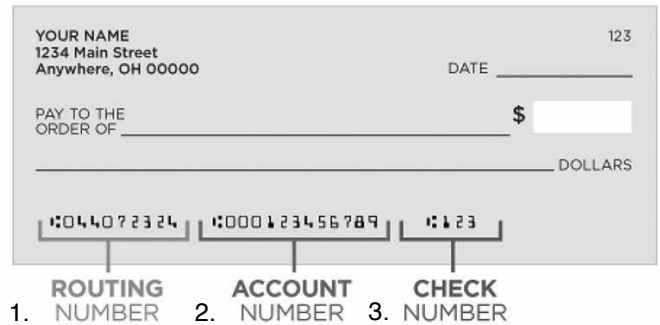
Authorized Signature(s) - (Not required if authorization by phone)

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 |: 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 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: (____) _____