

**Amateur Mixed Martial Arts  
 Event  
 Insurance Application**

**Name of Organization:** \_\_\_\_\_

C/O (Individual Responsible for Insurance): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (        ) \_\_\_\_\_ Fax: (        ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Venue Name:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date(s) of Event \_\_\_\_\_

**Spectator Liability Coverage - \$1,000,000 per occurrence/ \$2,000,000 per event. Plus \$300,000 in protection for damage to rented premises. Assault and Battery protection is included. See policy for details.**

Number of Spectators		Rate per Spectator		Premium Due
	X	\$0.25 - Venue Responsible for Security	=	(Minimum premium \$400.00)
	X	\$0.45 – Promoter Responsible for Security	=	(Minimum premium \$400.00)

**Increased Spectator Liability Limit to \$5,000,000 – More than \$1,000,000 in coverage may be required by some venues. Must be purchased with Spectator Liability Coverage above. Increases protection for assault and battery related incidents by \$1,000,000. See policy for details.**

	Rate		Premium Due
Venue Responsible for Security	\$500 flat rate + \$0.10 per spectator over 2000	=	(Minimum premium \$500.00)
Promoter Responsible for Security	\$550 flat rate + \$0.15 per spectator over 2000	=	(Minimum premium \$550.00)

# Professional Participant Accident Medical and AD&D Coverage

Choose either the event package and/or purchase coverage per fighter. See policy for details.

Does not include Events in California

## Event Package (Covers up to 20 Fighters, 10 Bouts)

Accident Medical Expense	Accidental Death and Dismemberment	Deductible Option	Rate Per Event Per Day		Premium Due
\$2,500	\$2,500	\$500	\$600	=	
		\$1,000	\$550	=	
		\$1,500	\$500	=	
\$5,000	\$5,000	\$500	\$700	=	
		\$1,000	\$650	=	
		\$1,500	\$600	=	
\$10,000	\$10,000	\$500	\$1,000	=	
		\$1,000	\$875	=	
		\$1,500	\$800	=	
\$20,000	\$20,000	\$500	\$1,450	=	
		\$1,000	\$1,200	=	
		\$1,500	\$1,000	=	
\$25,000	\$25,000	\$500	\$1,600	=	
		\$1,000	\$1,300	=	
		\$1,500	\$1,200	=	
\$20,000	\$50,000	\$500	\$1,675	=	
		\$1,000	\$1,375	=	
		\$1,500	\$1,275	=	
\$50,000	\$50,000	\$500	\$2,550	=	
		\$1,000	\$2,300	=	
		\$1,500	\$2,150	=	
\$50,000	\$100,000	\$500	\$6,300	=	
		\$1,000	\$2,600	=	
		\$1,500	\$2,400	=	
		\$5,000	\$1,500	=	
<b>Nevada Only: The rates below meet the Nevada requirements for Primary Medical.</b>					
\$50,000	\$50,000	\$500	\$8,750	=	
		\$1,000	\$8,270	=	

## Rates per Fighter

Accident Medical Expense	Accidental Death and Dismemberment	Deductible Option	Number of Fighters		Rate per Fighter		Premium Due
\$2,500	\$2,500	\$500		X	\$50	=	
		\$1,000		X	\$46	=	
		\$1,500		X	\$42	=	
\$5,000	\$5,000	\$500		X	\$58	=	
		\$1,000		X	\$54	=	
		\$1,500		X	\$50	=	
\$10,000	\$10,000	\$500		X	\$83	=	
		\$1,000		X	\$73	=	
		\$1,500		X	\$67	=	
\$20,000	\$20,000	\$500		X	\$121	=	
		\$1,000		X	\$100	=	
		\$1,500		X	\$83	=	
\$25,000	\$25,000	\$500		X	\$133	=	
		\$1,000		X	\$108	=	
		\$1,500		X	\$100	=	
\$20,000	\$50,000	\$500		X	\$140	=	
		\$1,000		X	\$115	=	
		\$1,500		X	\$106	=	
\$50,000	\$50,000	\$500		X	\$213	=	
		\$1,000		X	\$192	=	
		\$1,500		X	\$179	=	
\$50,000	\$100,000	\$500		X	\$525	=	
		\$1,000		X	\$217	=	
		\$1,500		X	\$200	=	
		\$5,000		X	\$125	=	
<b>Nevada Only: The rates below meet the Nevada requirements for Primary Medical.</b>							
\$50,000	\$50,000	\$1,000		X	\$729	=	
		\$1,500		X	\$689	=	

# Hired/Non-Owned Auto Coverage

Type of Coverage		Rate per Event		Premium Due
Basic Coverage	X	\$125	=	
<b>OR</b>				
Enhanced Coverage	X	\$175	=	

**Note: Coverage does not apply to vehicles with a gross vehicle weight over 10,000 lbs. Basic coverage includes \$1,000,000 of coverage. Enhanced coverage provides an additional \$1,000,000 of protection.**

**Is the promoter in charge of any of the following?**

Parking?        \_\_\_\_\_ Yes    \_\_\_\_\_ No  
 Concessions?    \_\_\_\_\_ Yes    \_\_\_\_\_ No  
 First Aid?        \_\_\_\_\_ Yes    \_\_\_\_\_ No  
 Maintenance?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

**Will you have Pro Fighters in this event? \_\_\_\_\_ If so, how many? \_\_\_\_\_**

**ALL PREMIUMS ARE FULLY EARNED AT POLICY INCEPTION**

**Total Amount From Premium Due Columns: \$ \_\_\_\_\_**

**+**

**Application Fee: \$ \_\_\_\_\_ 15 \_\_\_\_\_**

**=**

**Total Amount Due For Premiums and Fees: \$ \_\_\_\_\_**

Please sign and submit this application via mail, fax or e-mail along with payment by check for the above amount to:

**Gagliardi Insurance Services, Inc.**  
**284 Digital Drive**  
**Morgan Hill, CA 95037**  
**Phone: (800) 995-9768 Fax: (408) 414-8199**  
**E-Mail: [sales@gisins.com](mailto:sales@gisins.com)**

**I confirm that all information provided on this application is true to the best of my knowledge and understand that any inaccurate or misleading statements may affect any claims made against the associated policy. Gagliardi Insurance Services reserves the right to deny all or part of any coverage offered on this application. I understand that this application only provides a summary of coverage and that full details of the coverage or a copy of the insurance policies purchased can be provided upon request. I understand that insurance requirements vary by venue and state and I am responsible for ensuring that I have purchased adequate coverage based on the location of the event.**

**Date: \_\_\_\_\_ Applicant Signature: \_\_\_\_\_**

**Print Name and Title: \_\_\_\_\_**

Payment by credit card is optional. If desired, please complete and submit the credit card authorization form below:

**Credit Card Authorization Form (*Visa or MasterCard Only*)**

<b>Name (as it appears on card):</b>	
<b>Billing Address:</b>	
<b>Billing City, State and Zip Code:</b>	
<b>Credit Card Number: (VISA OR MASTERCARD ONLY)</b>	
<b>Expiration Date:</b>	
<b>V Code:</b> (3 number code on back of credit card)	
<b>Amount to Be Billed:</b> (An Expedite Fee of \$100.00 will be charged if needed within 72 hours)	
<b>Billing Date:</b>	
<b>Additional Comments: (Name of Insured/League/ Organization)</b>	

I, \_\_\_\_\_ (please print), authorize the use of my credit card described above for charges related to the services and products provided by Gagliardi Insurance Services, Inc.

\_\_\_\_\_  
**Cardholder's Signature**

\_\_\_\_\_  
**Date**

Gagliardi Insurance Services, Inc.  
284 Digital Drive  
Morgan Hill, CA 95037

Phone: (800) 995-9768 Fax: (408) 414-8199

# Additional Insured/Certificate Holder List

**\*\*Complete Address *MUST* be included for completion of certificate\*\***

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Certificate Holder

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Address

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City, State & Zip Code

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Certificate Holder

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➤ ***Attach additional list of certificate holders when necessary.***