



# 2010 Travel/Individual Team Insurance Program

Name of Organization \_\_\_\_\_

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

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

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

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

E-mail Address: \_\_\_\_\_  
 (We will use the above address for e-mailing a copy of certificates. Hard copies can be mailed upon request.)

With which governing organization(s) is your team affiliated? \_\_\_\_\_

## Program Coverage Summary

<u>Liability</u>	
\$2,000,000	General Aggregate
\$1,000,000	Per Occurrence
\$1,000,000	Personal and Advertising
\$1,000,000	Products/Completed Operations
\$ 300,000	Fire Legal
\$1,000,000	Non Owned and Hired Auto
\$1,000,000	Abuse and Molestation
**\$ 5,000	<u>Spectator Med Expense-(Available upon request)**</u>
<u>Medical</u>	
\$ 100,000	Maximum Medical Benefit (Option #1)
\$ 250,000	Maximum Medical Benefit (Option #2)
\$ 10,000	Accidental Death & Dismemberment
\$ 2,000	Accidental Dental Benefit

## Additional Protection Coverage Summary

**Crime/Theft Bond** – Protects your organization against employee fraud or dishonesty up to \$35,000. \$250 deductible.

**Directors and Officers Coverage** – Executive board member coverage providing up to \$1,000,000 per occurrence of liability coverage against discrimination, acts beyond granted authority, failure to deliver services, and failure to provide adequate insurance coverage. \$500 deductible.

**Sports Equipment Coverage** – Sport equipment coverage insures against loss or damage of all sports equipment, snack bar equipment, uniforms, and playing equipment. \$100 deductible.

**Playing Field Coverage** – This coverage extends the liability policy to cover your owned playing fields for 24 hours a day, 7 days a week.

## Program Rates

### Spectator/Third Party Liability Coverage

**Liability Rate** : \$40 per team = \$ \_\_\_\_\_

- Do you have written procedures requiring that a waiver and release be signed by all participants and parents prior to their participation? YES NO

#### Excess Liability Limit (Optional)

Rate Premium Due

(Increase to \$5,000,000) \$12.00 Per Team = \$ \_\_\_\_\_

## Participant Medical Rate Options

### \$100,000 Accident Medical Benefit (Option 1)

#### Baseball Rates (Per Team)

Age Group	\$50 Deductible	\$100 Deductible	\$250 Deductible	Premium Due
10 and Under	\$27.00	\$25.00	\$21.00	=
12 and Under	\$30.00	\$27.00	\$22.00	=
16 and Under	\$56.00	\$50.00	\$41.00	=
18 and Under	\$121.00	\$97.00	\$81.00	=
21 and Under	\$194.00	\$155.00	\$130.00	=

#### Softball Rates (Per Team)

Age Group	\$50 Deductible	\$100 Deductible	\$250 Deductible	Premium Due
12 and Under	\$25.00	\$22.50	\$18.75	=
16 and Under	\$54.00	\$48.60	\$40.50	=
21 and Under	\$110.00	\$99.00	\$82.50	=

To increase dental to \$3,000 add \$1 per team: (Optional) = \$ \_\_\_\_\_

#### Catastrophic Medical – (Optional)

To increase Medical benefits to \$500,000 add \$14.50 = \$ \_\_\_\_\_

## Participant Medical Rate Options (Continued)

### \$250,000 Accident Medical Benefit (Option 2)

#### Baseball Rates (Per Team)

Age Group	\$50 Deductible	\$100 Deductible	\$250 Deductible	Premium Due
10 and Under	\$32.50	\$30.00	\$25.00	=
12 and Under	\$36.00	\$32.50	\$26.50	=
16 and Under	\$67.00	\$60.00	\$49.00	=
18 and Under	\$145.00	\$116.50	\$97.00	=
21 and Under	\$233.00	\$186.00	\$156.00	=

#### Softball Rates (Per Team)

Age Group	\$50 Deductible	\$100 Deductible	\$250 Deductible	Premium Due
12 and Under	\$30.00	\$27.00	\$22.50	=
16 and Under	\$65.00	\$58.50	\$48.50	=
21 and Under	\$132.00	\$119.00	\$99.00	=

To increase dental to \$3,000 add \$1 per team: (Optional) = \$

#### Catastrophic Medical – (Optional)

To increase Medical benefits to \$500,000 add \$12.25 = \$

# Additional Protection Rates

## Crime/Theft Bond

\$35,000 of Coverage per Chapter/Association Premium Due  
 Rate \$180.00 X \_\_\_\_\_ = \_\_\_\_\_

- Are all monies and/or securities in a safe or lock box? YES NO
- Are bank accounts and ledgers either audited on a quarterly basis by an executive officer, or annually by an independent auditor? YES NO If no, please explain: \_\_\_\_\_
- Do you have more than 3 people handling money or securities? YES NO
  - If Yes, how many? \_\_\_\_\_

## Sports Equipment Coverage

Coverage amount (Rate Per \$100.00 in coverage) Premium Due  
 \_\_\_\_\_ X \$2.75 = \_\_\_\_\_  
Note: Minimum Premium is \$250.00

- Please attach a detailed list itemizing any covered items valued over \$1,000
- Is equipment stored in a locked facility? YES NO

Address where equipment is being kept: \_\_\_\_\_

▪ Coverage is void if equipment is stored at a residence or in a vehicle.

## Playing Field Coverage

Premium Due  
 # of fields owned: \_\_\_\_\_ X \$340 = \_\_\_\_\_

## Directors & Officers

\$1,000,000 of Coverage Premium Due  
 Rate \$340.00 X \_\_\_\_\_ = \_\_\_\_\_

- Have any loss payments been made under any prior or current D&O or similar insurance? YES NO
- Has any league person given written notice under the provisions of any prior D&O liability or similar insurance of circumstances which might give cause for a claim against any insured person(s)? YES NO
- Are you aware of any circumstance which would afford valid grounds for any future claim(s) which would fall within the scope of this coverage? YES NO

\*Presidents' Signature Required for Directors and Officers Coverage: \_\_\_\_\_

**New Clients: Has your league or team incurred any losses in the past 3 years?**

**YES/NO**

**If Yes, please describe in detail:**

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**G.A.R.D. TRUST**

**BASEBALL/SOFTBALL ACCIDENT MEDICAL**

**PARTICIPATION AGREEMENT**

The undersigned hereby requests to become a Participant in the G.A.R.D. Trust, established under a Trust Agreement entered into in the State of Rhode Island on the 1<sup>st</sup> day of October, 1987 as amended, by BankNewport as Successor Trustee to Citizens Bank of Rhode Island.

As a Participant, the undersigned shall be bound by the terms of the Trust Agreement and hereby appoints the Administrator to represent the Participant in all dealings with the Trustee having to do with the Insurance Fund.

If accepted as a Participant herein, the undersigned may, upon 30 days written notice, subject to the Trust Agreement, withdraw from the Trust, and terminate its participation therein. By any such withdrawal, a Participant shall relinquish all claims to any portion of the Insurance Fund on the date of withdrawal. In the event of any change to the insurance affecting this Participant, the Administrator shall provide the same notification to the Participant as provided the Trustee under the Master Policy identified below. The Participant agrees to notify all of its members once it is notified of any change to the insurance.

Executed on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

PARTICIPANT: (Name of Team) \_\_\_\_\_

Signature: \_\_\_\_\_

For information purposes only: Benefits for eligible persons of the Participant are provided under Master Policy 9906-4877.

ACCEPTED by the Trust Administrator:  
James R. Hamilton

By:   
Administrator

**G.A.R.D. TRUST**

**BASEBALL/SOFTBALL CATASTROPHIC MEDICAL**

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Executed on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

PARTICIPANT: (Name of Team) \_\_\_\_\_

Signature: \_\_\_\_\_

For information purposes only: Benefits for eligible persons of the Participant are provided under Master Policy 9906-4878.

ACCEPTED by the Trust Administrator:  
James R. Hamilton

By:   
Administrator

**Policy Effective Date Options: (Circle One)**

**1/1/2010-1/1/2011**

**3/1/2010-3/1/2011**

**5/1/2010-5/1/2011**

- **To add teams at any time during the policy year, please fill out a separate application and send it in to our office with premium included. Please ensure the wording “ADDING TEAMS” is clearly noted on the application.**
- **Policy will begin upon receipt of application and premium, and will be valid through the above selected date.**
- **ALL PREMIUMS ARE FULLY EARNED AT POLICY INCEPTION-Teams cannot be deleted or removed, and no refunds will be given.**

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

**+**

**Application Fee: \$ 20**

**=**

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

## Payment Options:

- **Check-by-Fax** (Fax a voided check with application.)
- **Check by mail**
- **Visa or MasterCard** (Authorization form attached)

Please sign and submit this application via mail, fax or e-mail along with your method of payment for the amount due 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

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. I verify I have read and understand all information contained in this application and that Gagliardi Insurance Services reserves the right to deny all or part of any coverage offered. 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 offered or purchased can be provided upon request. Insurance requirements may vary by venue and state. I understand that I am responsible for ensuring that I have purchased adequate coverage based on the location of the event or other covered activities.

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

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

## 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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Address

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City, State & Zip Code

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Certificate Holder

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Address

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City, State & Zip Code

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

## Credit Card Authorization Form

<b>Name (as it appears on the card):</b>	
<b>Billing Address:</b>	
<b>Billing City, State and Zip Code:</b>	
<b>Credit Card Number:</b> <i>Visa or Mastercard only.</i>	
<b>Expiration Date:</b>	
<b>V Code:</b> 3 Digit code on back of the credit card	
<b>Amount to Be Billed:</b> <ul style="list-style-type: none"> <li>• A \$100 expedite fee will be charged if same day service is requested.</li> </ul>	
<b>Billing Date:</b>	
<b>Additional Comments:</b> <b>(Name of Insured and/or Policy Number(s))</b>	

I, \_\_\_\_\_, 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