



2010 Girls Softball Insurance Program

(Only Pony registered teams/leagues are eligible for this 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.)

Program Coverage Summary

<u>Liability</u>	
\$2,000,000	General Aggregate
\$1,000,000	Per Occurrence
\$1,000,000	Personal and Advertising
\$2,000,000	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.

Participant Medical Rate Options (Continued)

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

Softball Rates (Per Team)

Age Group	\$50 Deductible	\$100 Deductible	\$250 Deductible	Premium Due
12 and Under	\$23.00	\$20.50	\$17.00	=
16 and Under	\$50.50	\$45.50	\$38.00	=
21 and Under	\$71.00	\$63.75	\$53.00	=

To increase dental to \$3,000 add \$1 per team = \$

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 \$300 = _____

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: _____

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 out.

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.

Certificate Holder

Address

City, State & Zip Code

Certificate Holder

Address

City, State & Zip Code

Certificate Holder

Address

City, State & Zip Code

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Certificate Holder

Address

City, State & Zip Code

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

Credit Card Authorization Form

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

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