

# Enrollment for Youth Sports Accident Insurance

## Enrollment Form for Accidental Death and Accident Medical Benefits

### Part I Proposed Policyholder *Please print or type*

a. Full Legal Name of Proposed Policyholder \_\_\_\_\_

b. Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Street City State Zip

c. Specified Activity \_\_\_\_\_

d. Requested Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_

*Policy will become effective on the Requested Effective Date if (a) all required information is provided and (b) the Company has received the initial premium on or before that date.*

### Part II Plan of Insurance and Premium Calculation

a. Plan of Benefits

Accidental Death & Dismemberment Principle Sum \$ \_\_\_\_\_

Maximum Medical Expense Benefit \$ \_\_\_\_\_

Deductible Amount \$ \_\_\_\_\_

Policy to cover All Players, Coaches, Managers, and Volunteers of the Policyholder

Scope of Coverage is Full Excess

b. Premium Calculation

Classification of Insured Persons or Group	Age Group	Number Eligible	Rate Per Player	Total Rate
_____	_____	_____	x \$ _____	= _____
_____	_____	_____	x \$ _____	= _____
_____	_____	_____	x \$ _____	= _____
_____	_____	_____	x \$ _____	= _____
_____	_____	_____	x \$ _____	= _____

Total Premium: \$ \_\_\_\_\_

Discounts (if applicable): \$ \_\_\_\_\_

Total Premium Due: \$ \_\_\_\_\_

*Minimum Premium is \$150.00*

### Part III Acknowledgements and Signatures

a. **Fraud Warning** Any person who, knowingly and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information, may be guilty of insurance fraud.

b. **Applicant's Acknowledgement** I, the applicant, declare, to the best of my knowledge and belief, that all statements and answers in this application are true and complete. I understand and agree that (a) this application will form part of any policy issued, (b) no information given to or acquired by any representative of the Company will bind it, unless it is in writing on this application, (c) no waiver or modification will bind the Company unless it is in writing and is signed by an executive officer of the Company, and (d) only those persons eligible under the terms of an issued policy will be insured.

Date \_\_\_\_\_

Signed by Licensed Agent \_\_\_\_\_

Agent Phone Number \_\_\_\_\_

Signed for the Proposed Policyholder \_\_\_\_\_

Licensed Agent Number \_\_\_\_\_

Title \_\_\_\_\_

Agent Address \_\_\_\_\_

Francis L. Dean & Associates, Inc.



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Underwritten by:



**Capitol Insurance Companies**  
Capitol Indemnity Corporation  
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