



Youth Camp and Clinic Supplemental Request Form

For Adding Additional Camp and/or Clinic Session Dates

This supplemental is valid for effective dates from 3/1/21 through 2/28/22

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: _____

EXPOSURE INFORMATION

Please note:

- You must submit this request form prior to the start of your camp and/or clinic
- You must provide the actual or maximum amount of expected campers. TBD numbers can not be accepted
- You may be subject to an audit
- Cancellations must be reported in writing on or before the start of the camp and/or clinic session
- Should you have \$1,000,000 of Sexual Abuse or Sexual Molestation Liability coverage in place with us, you will need to rate for this additional exposure with any increments you may add below on the next page.

1. Do any of your camps include any of the following sports? Yes No

If yes, please check those that apply and answer questions a. and b.

<input type="radio"/> Cheerleading	<input type="radio"/> Gymnastics	<input type="radio"/> Roller hockey (quad)
<input type="radio"/> Deck/floor/street hockey	<input type="radio"/> Ice Hockey	<input type="radio"/> Soccer
<input type="radio"/> Field hockey	<input type="radio"/> Inline Hockey	<input type="radio"/> Water hockey
<input type="radio"/> Football	<input type="radio"/> Lacrosse	<input type="radio"/> Wrestling

a. If you suspect an athlete has a concussion, do you have an action plan that includes:

- Immediately removing the athlete from play or practice Yes No
- Keeping the athlete out of play or practice until they provide written clearance from a licensed physician? Yes No

b. Does your operation involve football? Yes No

If yes,

Do you maintain a system for your football activities that includes communication (in written or electronic form) of education materials to participants, parents and coaches about the nature of risk of concussions, including but not limited to information such as: focusing on prevention and preparedness to keep athletes safe; understanding concussions and potential consequences of the injury; recognizing concussion symptoms and how to respond; and learning about steps for returning to play after a suspected concussion? Yes No

Note: The Center for Disease Control and Prevention offers free information, as well as a free online concussion training course for coaches on their website: www.cdc.gov/concussion/HeadsUp/youth.html.

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

Please complete. Should you have more than 4 camps to add, please provide information on an additional sheet.

Program Liability

Rates - Class 1 & 2	Refer to brochure for applicable rates or contact K&K
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PREMIUM CALCULATION

Camp #	List All Sessions Individually	Type of Sport/Camp	Rate	X	Actual # of Campers/Participants	=	Premium
1	Date(s): _____ Location: _____ Hours of Operation: _____		\$	X		=	\$
2	Date(s): _____ Location: _____ Hours of Operation: _____		\$	X		=	\$
3	Date(s): _____ Location: _____ Hours of Operation: _____		\$	X		=	\$
4	Date(s): _____ Location: _____ Hours of Operation: _____		\$	X		=	\$
Program Premium Due: Add all premium lines above to obtain premium due							\$

Sexual Abuse or Sexual Molestation Liability (optional coverage)

Check one

- I currently have Sexual Abuse or Molestation Liability Coverage in place and need to add the additional participants/parties reported on the prior page to my coverage.
- I would like to add this coverage to my policy.

* **Note:** If you would like to add this coverage to your policy mid-term, please contact us for additional information on the proper form to complete for review and approval.

Rates: Daily Rate = \$.15		Weekly Rate = \$.45		Overnight/Resident Rate = \$.59			
Camp/Session # (as reported on previous page)	# of Days OR Weeks	X	Daily OR Weekly Rate (from above)	X	#of Campers	=	Premium
		X	\$	X		=	\$
		X	\$	X		=	\$
		X	\$	X		=	\$
Total Sexual Abuse or Sexual Molestation Liability Premium							\$

PAYMENT DUE		
	Program Liability Premium	\$
	Sexual Abuse or Sexual Molestation Liability Premium	\$
	Total Premium Due (add lines above)	\$

Complete this section if you require additional certificates listing a facility, property owner or similar third-party as 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.

CERTIFICATE REQUEST #1

1. Camp #: _____

2. When is this certificate needed? : ____/____/____

3. What is the additional insured's relationship to you?

Owner/manager/lessor of premises (facility or venue) Sponsor Co-promoter

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.

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.

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CERTIFICATE REQUEST #2

1. Camp #: _____

2. When is this certificate needed? : ____/____/____

3. What is the additional insured's relationship to you?

Owner/manager/lessor of premises (facility or venue) Sponsor Co-promoter

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.

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.

PAYMENT OPTIONS

Submit a completed supplemental and payment to:

Applicant business 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: _____

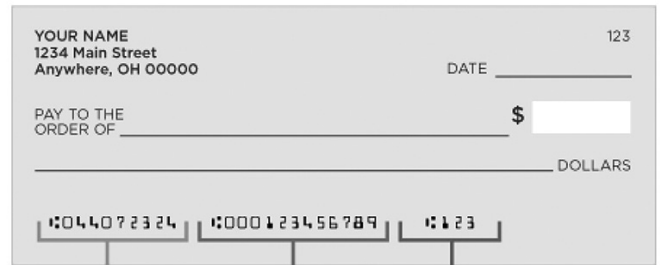
Authorized Signature(s) - (Not required if authorization by phone)

_____ 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.



1. ROUTING NUMBER 2. ACCOUNT NUMBER 3. CHECK NUMBER

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: (____) _____