COLLEGE ATHLETIC ACCIDENT MEDICAL

Eligible Operations:

- Intercollegiate (NCAA/NJCAA/NAIA) athletic programs
- Collegiate clubs and intramural sports programs

Ineligible for this program:

- Student Accident and Sickness Program (Non-Athletic)

K&K Benefits:

- Experienced & professional staff dedicated exclusively to servicing the K&K Coaches/ Officials Program
- Active participation in industry trade shows and meetings
- Over 70 years of experience providing sports, leisure and entertainment insurance
- In-house underwriting, policy administration, loss control and claims services
- 24-hour emergency claims phone service
- Insurance carriers rated “A” or higher by A.M. Best

Accident medical insurance solutions for colleges and universities insuring their student athletes participating in intercollegiate athletic programs. Coverage can extend to college club and intramural programs.

Coverages Available & Program Highlights:

Excess Accident Medical

- Up to $90,000 policy limit for NCAA Colleges and Universities
- Multiple deductible options including No Deductible and Aggregate Deductibles
- Expanded Medical coverage
- Coverage for HMO/PPO denials
- Coverage for pre-existing conditions

Catastrophic Accident Medical

Insuring the world’s fun®

Contact Information:

P.O. Box 2338 Fort Wayne, IN 46801-2338

College Athletic Accident Medical Program

PHONE: **800-441-3994**
FAX: **260.459.5120**

EMAIL:
KK.Sports@kandkinsurance.com

WEB SITE:
www.kandkinsurance.com

K&K Insurance Group, Inc. is a licensed insurance producer in all states (TX license #13924); operating in CA, NY and MI as K&K Insurance Agency (CA license #0334819)

All descriptions, summaries or highlights of coverage are for general informational purposes only and do not amend, alter or modify the actual terms or conditions of any insurance policy. Coverage is governed only by the terms and conditions of the relevant policy.

Submission Instructions:

To request an insurance quotation through this program, please complete the appropriate PDF application (available at www.kandkinsurance.com) and submit as directed in the application. Coverage is subject to underwriting, may not be available to all applicants in all states, and may vary by state. It is important to carefully review the terms and conditions of any insurance quotation. Please contact a K&K representative if you have any questions.

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Fax (260) 459-5120 CA# 0334819
www.kandkinsurance.com

INTERCOLLEGIATE SPORTS ONLY
BASIC MEDICAL INSURANCE PROGRAM
QUOTATION REQUEST FORM

Name of School:_____

Web Site:_____

Mailing Address:_____

City:_____ State: _____ Zip:_____

Information Provided By:_____ Title:_____

Phone:_____ Fax: _____ E-mail Address:_____

Sports Sanctioning Body:_____ Division:_____

NUMBER OF PARTICIPANTS

	Men	Women		Men	Women		Men	Women
ARCHERY			GOLF			SWIM/DIVE		
BADMINTON			GYMNASTICS			TENNIS		
BAND			ICE HOCKEY			TRACK & FIELD		
BASEBALL			KARATE/JUDO			VOLLEYBALL		
BASKETBALL			LACROSSE			WATER POLO		
BOWLING			RIFLE			WRESTLING		
BOXING			RODEO			OTHERS (LIST)		
CHEERLEADERS			ROWING/CREW			_____		
CROSS COUNTRY			RUGBY			_____		
CYCLING			SAILING			_____		
EQUESTRIAN			SKIING			_____		
FENCING			SOCCER			_____		
FIELD HOCKEY			SOFTBALL			_____		
FOOTBALL, FALL			STUDENT MANAGERS			_____		
FOOTBALL, SPRING			SQUASH/RACQUETBALL			_____		

1. PREVIOUS INSURANCE INFORMATION: Please provide copies of claim reports from your prior insurance carrier(s).

	Three Years Prior	Two Years Prior	One Year Prior	Current Year
Maximum Medical Coverage	$	$	$	$
Excess or Primary				
Deductible	$	$	$	$
Full Coverage for Pre-Existing Conditions	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Full Coverage for HMO/PPO Denials	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Benefit Period Limit				
Accidental Death Maximum Limit	$	$	$	$
Premium	$	$	$	$
Number of Claims Paid				
Benefits Paid	$	$	$	$
as of (Date)				
Name of Insurer				

2. RISK MANAGEMENT INFORMATION:

Certified athletic trainer(s) on staff? ❑ Yes ❑ No

If yes, for which sports is trainer responsible?_____

_____

Team Physician: ❑ On Staff ❑ On Retainer ❑ Other (please describe)_____

_____

Physician's Specialty:_____

Is physician board certified? ❑ Yes ❑ No

Does the athletic department or coaching staff routinely:

Obtain information about athlete's other insurance coverage? ❑ Yes ❑ No

Require pre-participation physical examination? ❑ Yes ❑ No

If yes, for which sports?_____

_____

Type of institution? ❑ Public ❑ Private

Type of surface where activities take place? ❑ Artificial ❑ Grass

What other activities take place on this surface?_____

_____

Does your institution have a medical school which provides care at no cost to the athletes? ❑ Yes ❑ No

What percentage of your student athletes have primary medical coverage?_____

This is not an offer of coverage nor an application for insurance. Requests for coverage will be subject to company underwriting standards. Actual coverage terms will be described in a policy of insurance if one is issued.
I understand that the insurance company in determining whether to provide a quotation for insurance coverage will rely on the information contained in the form and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

_____ _____

Applicant's Signature | Producer's Signature (if applicable)

_____ _____

Applicant's Name (print) | Producer's Name (print)

_____ _____

Date (MM/DD/YY) | Date (MM/DD/YY)

Please mail or fax both sides of this form to:

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CLUB/INTRAMURAL SPORTS ONLY
BASIC MEDICAL INSURANCE PROGRAM
QUOTATION REQUEST FORM

Name of School:_____

Web Site:_____

Mailing Address:_____

City:_____ State: _____ Zip:_____

Information Provided By:_____ Title:_____

Phone:_____ Fax: _____ E-mail Address:_____

Sports Sanctioning Body:_____ Division:_____

NUMBER OF PARTICIPANTS

	Men	Women		Men	Women		Men	Women
ARCHERY			GOLF			SWIM/DIVE		
BADMINTON			GYMNASTICS			TENNIS		
BAND			ICE HOCKEY			TRACK & FIELD		
BASEBALL			KARATE/JUDO			VOLLEYBALL		
BASKETBALL			LACROSSE			WATER POLO		
BOWLING			RIFLE			WRESTLING		
BOXING			RODEO			OTHERS (LIST)		
CHEERLEADERS			ROWING/CREW			_____		
CROSS COUNTRY			RUGBY			_____		
CYCLING			SAILING			_____		
EQUESTRIAN			SKIING			_____		
FENCING			SOCCER			_____		
FIELD HOCKEY			SOFTBALL			_____		
FOOTBALL, FALL			STUDENT MANAGERS			_____		
FOOTBALL, SPRING			SQUASH/RACQUETBALL			_____		

1. PREVIOUS INSURANCE INFORMATION: Please provide copies of claim reports from your prior insurance carrier(s).

	Three Years Prior	Two Years Prior	One Year Prior	Current Year
Maximum Medical Coverage	$	$	$	$
Excess or Primary				
Deductible	$	$	$	$
Full Coverage for Pre-Existing Conditions	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Full Coverage for HMO/PPO Denials	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Benefit Period Limit				
Accidental Death Maximum Limit	$	$	$	$
Premium	$	$	$	$
Number of Claims Paid				
Benefits Paid	$	$	$	$
as of (Date)				
Name of Insurer				

2. RISK MANAGEMENT INFORMATION:

Certified athletic trainer(s) on staff? ❑ Yes ❑ No

If yes, for which sports is trainer responsible?_____

_____

Team Physician: ❑ On Staff ❑ On Retainer ❑ Other (please describe)_____

_____

Physician's Specialty:_____

Is physician board certified? ❑ Yes ❑ No

Does the athletic department or coaching staff routinely:

Obtain information about athlete's other insurance coverage? ❑ Yes ❑ No

Require pre-participation physical examination? ❑ Yes ❑ No

If yes, for which sports?_____

_____

Type of institution? ❑ Public ❑ Private

Type of surface where activities take place? ❑ Artificial ❑ Grass

What other activities take place on this surface?_____

_____

Does your institution have a medical school which provides care at no cost to the athletes? ❑ Yes ❑ No

What percentage of your student athletes have primary medical coverage?_____

This is not an offer of coverage nor an application for insurance. Requests for coverage will be subject to company underwriting standards. Actual coverage terms will be described in a policy of insurance if one is issued.

I understand that the insurance company in determining whether to provide a quotation for insurance coverage will rely on the information contained in the form and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

_____ _____

Applicant's Signature | Producer's Signature (if applicable)

_____ _____

Applicant's Name (print) | Producer's Name (print)

_____ _____

Date (MM/DD/YY) | Date (MM/DD/YY)

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WILDFIRE PREVENTION QUESTIONNAIRE

PLEASE NOTE - This application is to be used when the risk is in one of the following 15 states: Alaska, Arizona, California, Colorado, Florida, Idaho, Montana, New Mexico, Nevada, Oklahoma, Oregon, Texas, Utah, Washington, Wyoming.

NAMED INSURED *(as will appear on policy)*:_____

1. What are your procedures for clearing brush/debris/shrubs/vegetation and other combustible materials from around buildings and the property in general to help prevent the spread of wildfires (*should be 100' of clearance*)?
   _____
   _____
2. Are trees and branches pruned back to a minimum of 10 feet from all buildings? ☐ Yes ☐ No
3. Is the property served by the local municipal water system? ☐ Yes ☐ No
   If not, what water is immediately available for firefighting? (*e.g., Water tower, pumper truck, pond, lake, stream with capability of pumping water into a fire*) _____
   _____
4. Name of the fire department serving your facility: _____
   Fire Department Address: _____
   City:_____ State:_____Zip: _____
5. What is the distance of the fire department listed above from your facility?_____
   Is it full-time or volunteer?_____
6. Are the access roads to your facility paved and reasonably maintained all year? ☐ Yes ☐ No
7. Are the majority of your interior roadways (check one): ☐ Paved ☐ Gravel ☐ Dirt
   Are there any steep grades that could hinder vehicle movement? ☐ Yes ☐ No
8. Type of fire prevention material on site (*e.g., Fire Gel, Fire Retardant, Foam*)? _____
   _____
9. Explain the training you have received on applying the fire prevention material: _____
   _____
   _____
10. What is the breakdown of roofing materials on your buildings? _____% Asphalt_____% Metal
    _____% Tile/Slate
    _____% Other (describe)_____
11. _____% Percentage of buildings that have protective screens on all exterior openings such as sub-floor ventilation/crawl spaces and attic louvers to prevent the entry of windblown sparks, flying firebrands and embers.
12. Describe any type of natural breaks or man-made fire breaks surrounding the property:_____
    _____
    _____

I understand that the insurance company in determining whether to provide a quotation for insurance coverage will rely on the information contained in the application and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

_____	_____
Applicant's Signature	Producer's Signature (if applicable)
_____	_____
Applicant's Name (print)	Producer's Name (print)
_____	_____
Date (MM/DD/YY)	Date (MM/DD/YY)

MANDATORY SIGNATURE SUPPLEMENT

THE NOTICES CONTAINED ON THIS SUPPLEMENT APPLY TO ALL UNDERWRITING INFORMATION BEING SUBMITTED TO K&K INSURANCE GROUP, INC., INCLUDING APPLICATIONS, QUESTIONNAIRES AND ENROLLMENT FORMS, FOR THE FOLLOWING PERSON OR ENTITY:

Applicant name:_____

I understand that K&K Insurance Group, Inc., for the insuring company, shall be permitted but not obligated to inspect a proposed insured's, or an insured's, property and operations for underwriting purposes at any time. Neither the right to make an underwriting inspection nor the making thereof nor any report thereon shall constitute an undertaking, on behalf of or for the benefit of any insured, or other, to determine or warrant that such property or operations are safe or healthful, or in compliance with any standards, rules or regulations. Underwriting inspections when conducted are for the sole purpose of determining and/or improving the insurability of certain property and operations and not safety. I also understand that an insured is solely responsible for the safety of its facilities and operations and shall not rely upon any underwriting inspections to determine the safety of its facilities or operations and shall not diminish or forego its own safety practices and procedures.

I understand that the insurance company in determining whether to provide a quotation for insurance coverage will rely on the information contained in the application and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

I also understand that no insurance will be in effect unless and until the insurance company, or K&K as its agent, provides a quotation offering to provide insurance coverage and the insurance company, or K&K as its agent, receives written notice that the terms and conditions contained in the insurance quotation provided are accepted.

I agree that my electronic signature is the legally binding equivalent to my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

APPLICANT'S SIGNATURE	PRODUCER'S SIGNATURE (if applicable)
PRINT NAME	PRINT NAME
DATE (MM/DD/YY)	DATE (MM/DD/YY)