



P.O. Box 2338  
 Fort Wayne, IN 46801-2338  
 1-800-440-5580 Fax 1-260-459-5810  
 www.kandkinsurance.com  
 CA# 0334819

# JOCKEY ACCIDENT MEDICAL PROPOSAL REQUEST FORM

**Insuring the world's fun!**

Insured name (as will appear on policy): \_\_\_\_\_

Mailing address: \_\_\_\_\_

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

Track name: \_\_\_\_\_

Track address: \_\_\_\_\_

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

Contact person: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

## PROPOSAL INFORMATION

1. Proposed effective date: \_\_\_\_\_

2. Current accident policy:

Medical maximum \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_ Coinsurance \_\_\_\_\_ %

Disability benefit \$ \_\_\_\_\_ Elimination period: \_\_\_\_\_ Weeks/months payable: \_\_\_\_\_

AD&D benefit \$ \_\_\_\_\_ Special features: \_\_\_\_\_

Expiration date: \_\_\_\_\_

Who is covered?  Jockeys  Trainers  Exercisers  Owners  Other specify other: \_\_\_\_\_

3. Please provide the following information for the current year meet(s):

<u>Meet dates</u>	<u>Number of race days</u>	<u>Number of steeplechase races</u>
1st _____	_____	_____
2nd _____	_____	_____
3rd _____	_____	_____
4th _____	_____	_____

4. List dates of stabling/training days (do not include dates of meets):

<u>Dates</u>	<u>Number of days</u>
_____	_____
_____	_____
_____	_____
_____	_____

5. Please provide the total number of live race days for the prior 5 years.

Year _____ # of Live Race Days _____	Year _____ # of Live Race Days _____
Year _____ # of Live Race Days _____	Year _____ # of Live Race Days _____
Year _____ # of Live Race Days _____	

**TRACK INFORMATION:**

6. Outer rail construction material: \_\_\_\_\_ Outer rail height: \_\_\_\_\_  
 Manufacturer of outer rail: \_\_\_\_\_ Date installed: \_\_\_\_\_
7. Inner rail construction material: \_\_\_\_\_ Inner rail height: \_\_\_\_\_  
 Manufacturer of inner rail: \_\_\_\_\_ Date installed: \_\_\_\_\_
8. How often is the track inspected? \_\_\_\_\_
9. Are the use of helmets, flak jackets, and goggles mandatory?  Yes  No
10. Does an ambulance:
- a. Follow the field?  Yes  No
- b. Remain stationed trackside?  Yes  No
- c. Other (describe): \_\_\_\_\_
11. Is night or twilight racing conducted?  Yes  No
- a. If yes, is the track equipped with lighting sufficient to illuminate the entire racing surface?  Yes  No
- b. Is there a backup (emergency) lighting system?  Yes  No
- c. Does the backup system automatically activate in the event of a power loss?  Yes  No
- d. How is the power for the backup system generated? \_\_\_\_\_
12. Please provide details of vehicle traffic during workouts and race times: \_\_\_\_\_  
 \_\_\_\_\_

**LOSS INFORMATION:**

<u>Policy Period</u>	<u>Premium</u>	<u>Paid Claims</u>	<u>Claims as of</u>	<u>Racing Season</u>	<u>Racing Days</u>	<u>Covered Charges</u>

Describe any claims of more than \$50,000 or other unusual events:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

**Please enclose the following items along with this form and forward to K&K Insurance Group, Inc.:**

- Past five years insurance company loss runs
- Copy of current policy

I understand that the insurance company in determining whether to provide a quotation for insurance coverage will rely on the information contained in this 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)