Amateur Sports Adult Soccer Teams, Leagues & Associations Supplemental Request Form

This supplemental is valid for effective dates from 3/1/25 through 2/28/26

Please retain a copy of this form for your records.

GENERAL INFORMATION

Named insured (as it appears on your Member Certificate):_____

Policy number (as it appears on your Member Certificate): _____

Mailing address: _____

NY Applicants must provide a street address. PO Boxes cannot be accepted.

City: _____ State: _____ Zip: _____

Contact name: _____ Phone: (_____) _____

Cell: (_____) _____ Fax: (_____) _____

E-mail: _____ Website: _____

IMPORTANT INFORMATION

Notes:

- You must submit this request form prior to the effective date needed
- Coverage will be made effective the day after this request form and payment are received, or on a later date that you may specify
- All participants are required to be reported. TBD numbers cannot be accepted
- A current and complete roster with names and ages (ages only, no birthdates) of all participants is required to bind coverage. All participants must sign waivers
- You must choose the same coverage option that is currently bound and in effect

❍ Adding additional participants

Effective date needed: _____/_____/_____

ADDITIONAL PARTICIPANT PROGRAM RATES

Use these rates to figure out your premium on the next page.

Coverage Option	$1,000,000 CGL Limit	$2,000,000 CGL Limit	$3,000,000 CGL Limit	$4,000,000 CGL Limit	$5,000,000 CGL Limit
Option 1 Commercial General Liability with $1,000,000 Legal Liability to Participants and $10,000 Medical Payments for Participants	$35.91	$39.78	$41.71	$42.87	$43.72
Option 2 Commercial General Liability with $500,000 Legal Liability to Participants and Medical Payments for Participants Excluded	$7.42	$11.13	$12.99	$14.10	$14.91
Option 3 Commercial General Liability Only Legal Liability to Participants and Medical Payments for Participants are both Excluded	$5.18	$7.77	$9.07	$9.84	$10.41

Note: Rates include Limited Neurodegenerative Injury Coverage to Specified Players for Sports or Athletic Activities. If you did not purchase this coverage, adjustments will be made at the time of binding.

SEXUAL MISCONDUCT LIABILITY RATES

Use only if you were approved and purchased this optional coverage at the time of your original binding

Option 1	Option 2	Option 3
$1.30	$1.24	$1.04

ADDITIONAL PARTICIPANTS PREMIUM CALCULATION

Coverage Option 1, 2 or 3	# of Players Age 18 and Over	+	# of Players Age 16 to 17	=	Total # of Players	x	Rate (see pg 1)	=	Program Premium Due
									(a)

Does your current policy include Sexual Misconduct Liability Coverage? ❍ Yes ❍ No If yes, you will need to include rating from the prior page for this coverage.	

Total Number of Players from above	=		x	**Rate** (see pg 1) **$**	=	(b)
Total Premium Due (add lines a + b):					=	

CERTIFICATE REQUESTS

<u>Complete this section if you require additional certificates listing a facility, property owner or similar third-party as an additional insured on your policy.</u> 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.

1. When is this certificate needed? : _____/_____/_____ This certificate is for: ❍ General Liability Coverage

2. 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

3. Certificate holder/additional insured name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

4. 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.

If applicable:

5. For specific events: Date(s) of event/activity: _____/_____/_____ to _____/_____/_____

Hours of event/activity: _____ A.M./P.M. to _____ A.M./P.M.

Type of event/activity: _____ Name of event/activity: _____

Location of event/activity: _____

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.

K&K Insurance Group, Inc. • P.O. Box 2338 • Fort Wayne, IN 46801-2338 • 1-800-426-2889 • Fax 1-260-459-5105
www.kandkinsurance.com

FINAL PAYMENT CALCULATION AND PAYMENT OPTIONS

Step 1: Applicant Business Name from page 1_____

Step 2: Enter Additional Participants Premium from page 2: $_____(a)

Step 3: Calculate Surplus Lines/Stamping/Transaction Fees – this is based on the Named Insured's state from page 1

NOTE: If your state is not specifically listed, use the last column labeled "All Other States". All states must calculate a surplus lines/stamping/transaction fee.

Insured's State	HI	IL	MI	MT	NV	NY	OK	UT	WY	All Other States
Surplus Line Tax	.0468	.035	.025	.0275	.035	.036	.06	.0425	.03	.025
Stamping/Transaction Fee	N/A	.0004	N/A	N/A	.004	.0015	.00175	.0018	.00175	N/A
FINAL STATE RATE	**.0468**	**.0354**	**.025**	**.0275**	**.039**	**.0375**	**.06175**	**.0443**	**.03175**	**.025**

Premium from Step 2 -$_____(a) x **Final State Rate** from chart above $_____ = $_____(b)

Step 4: Cost Total (add lines a + b) $_____

Step 5: Select Payment Option

❍ ACH – this option is only available for purchases made 15 days or more prior to the effective date

Proceed to the next page to complete the ACH payment

❍ Mail in Check – make check payable to K&K Insurance Group

K&K Insurance
Soccer RPG Program
P.O. Box 2338
Fort Wayne, IN 46801-2338

❍ Credit Card

Proceed to the next page to complete the credit card payment

PAYMENT OPTIONS

100% of the premium and ROSTER (name and age) are due upon receipt of this supplemental
Submit a completed supplemental and payment via one of the options below.

Applicant business name: _____ Effective date: _____

PAY BY ACH (Bank Account): THIS OPTION IS ONLY AVAILABLE FOR PURCHASES MADE 15 DAYS OR MORE PRIOR TO THE EFFECTIVE DATE

- **E-mail** info@sportsinsurance-kk.com
  or
- **Fax** 1-260-459-5105

I (we) authorize K&K Insurance Group to initiate a single electronic debit from the account shown below and have attached a voided copy of the check.

Name on Bank Account: _____ Bank Name:_____

Draft Amount : $_____ ❍ Checking, or ❍ Savings

Bank Routing Number*_____ Bank Account Number* _____

*See below for an explanation of where to locate these two sets of numbers on your bank check.

_____ Date: _____

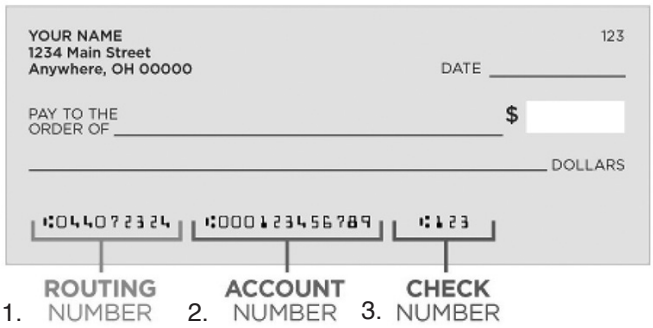
Authorized Signature(s) - (Not required if authorization by phone by K&K)

_____ Date: _____

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

EXPLANATION OF CHECK NUMBERS

1. Bank Routing Number - This is a nine digit number separated by a bar and a colon I: 123456789 I:
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.



PAY BY CREDIT CARD:

- **Fax only** 1-260-459-5105

❍ VISA ❍ MASTERCARD ❍ DISCOVER ❍ AMERICAN EXPRESS

Card number: _____

CSC # (card security) code: _____ Expiration date: _____

I authorize K&K Insurance Group, Inc. to charge my payment to my credit card in the amount of $_____

Print name (as on card):_____

Cardholder signature: _____

Cardholder phone number: (____)_____

FATCA Notice: Please go to Aon.com/FATCA to obtain appropriate W-9.