K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, IN 46801-2338
(800) 441-3994 / (260)459-5588
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:

K&K INSURANCE®

1712 Magnavox Way P.O. Box 2338
Fort Wayne, IN 46801-2338
(800) 441-3994 / (260)459-5588
Fax (260) 459-5120 CA# 0334819
www.kandkinsurance.com