



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

This supplemental is valid for effective dates from 3/1/22 through 2/28/23

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

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 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: ____/____/____

Coverage Options		Rates	
Option 1	\$ 1,000,000 Commercial General Liability \$ 1,000,000 Participant Legal Liability \$ 10,000 Medical Payments for Participants with \$1,000 corridor deductible	w/ Limited \$1,000,000 Brain Injury Coverage* \$ 35.91	w/ Brain Injury Excluded \$ 34.66
Option 2	\$ 1,000,000 Commercial General Liability \$ 500,000 Participant Legal Liability EXCLUDED Medical Payments for Participants	w/ Limited \$500,000 Brain Injury Coverage* \$ 7.42	w/ Brain Injury Excluded \$ 6.22
Option 3	\$ 1,000,000 Commercial General Liability EXCLUDED Participant Legal Liability EXCLUDED Medical Payments for Participants	\$ 5.18 per participant	

* LIMITED BRAIN INJURY - "Brain injury means concussion, chronic traumatic encephalopathy or any other injury to the brain and any symptoms, conditions, disorders and diseases, including death, resulting therefrom but only if such injury occurs as a result of specific events occurring during the policy period.

Coverage Option (1-3)	Number of Players Age 18 and Over	+	Number of Players Age 16 to 17	=	Total Number of Players	X	Rate	=	Program Premium Due
		+		=		X		=	\$

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

K&K Insurance Group, Inc. is a licensed insurance producer in all states (FL license #L007299, TX license #13924); operating in CA, NY and MI as K&K Insurance Agency (CA license #0334819)

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.

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.

PAYMENT OPTIONS

100% of the premium and **ROSTER** are due upon receipt of this supplemental

Submit a completed supplemental and payment to:

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 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 by K&K)

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

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.

YOUR NAME 1234 Main Street Anywhere, OH 00000 123 DATE _____

PAY TO THE ORDER OF _____ \$ _____ DOLLARS

⑆044072324⑆ ⑆000123456789⑆ ⑆123⑆

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

PAY BY CHECK: (Payable to K&K Insurance Group)

- **Mail** Regular Mail Overnight Mail
K&K Insurance Soccer RPG Program P.O. Box 2338 Fort Wayne, IN 46801-2338
K&K Insurance Soccer RPG Program 1712 Magnavox Way Fort Wayne, IN 46804

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.