



**APPLICATION for: Intercollegiate Sports Accident Insurance**

Institution: \_\_\_\_\_

Affiliation: \_\_\_\_\_ Division: \_\_\_\_\_

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

Contact Person: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Website: \_\_\_\_\_ Contact Email: \_\_\_\_\_

Date Quote Needed (MM/DD/YYYY): \_\_\_\_\_

**Census of Insured Sports**

	Male	Female	Total		Male	Female	Total
Baseball				Skiing			
Basketball				Soccer			
Bowling				Swimming			
Boxing				Tennis			
Cheerleading				Track/Field			
Cross Country				Volleyball			
Field Hockey				Water Polo			
Football (Fall)				Weightlifting			
Football (Spring)				Wrestling			
Golf				Student Coaches			
Gymnastics				Student Managers			
Ice Hockey				Student Trainers			
Lacrosse				Other			
Rowing/Crew				Other			
Rugby				Other			
<b>Total</b>				<b>Total</b>			

**Prior Insurance Data**

	20__ - 20__	20__ - 20__	20__ - 20__	20__ - 20__
Insurance Company				
Medical Expense Limit				
AD&D Limit				
Deductible Per Claim				
Benefit Period				
Aggravation/Reinjury	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Expanded Medical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HMO/PPO Denial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart/Circulatory	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Invited Guests	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Premium Paid				
Number of Claims Paid				
Claims Paid Report Date				
Name of Claims payor/TPA				

Requested Coverage Changes: \_\_\_\_\_

**\*IN ORDER TO OBTAIN QUOTES, WE MUST HAVE COPIES OF YOUR DETAILED, LOSS/CLAIMS REPORTS FOR THE LAST 4 YEARS (TRUE LOSSES EXCLUDING ADMIN FEES)**

**Risk Management Information**

Certified Athletic Trainer (s) on staff?  Yes  No

Team Physician:  On Staff  On Retainer  Other: \_\_\_\_\_

Require pre-participation physical examination?  Yes  No

Type of institution?  Public  Private

What percentage of your athletes have primary medical coverage? \_\_\_\_\_ %

Does your school have any special billing and/or payment arrangements with hospitals, physicians, or other providers?  Yes  No

If yes, please explain: \_\_\_\_\_

**Agent Information**

Agent: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

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