



**ATHLETIC ACCIDENT MEDICAL INSURANCE
QUOTATION REQUEST FORM**

NAME OF INSTITUTION _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CONTACT NAME _____ TITLE _____

PHONE _____ FAX _____

PART A – COVERED PARTICIPANTS

SPORTS	MEN	+	WOMEN	=	TOTAL
BAND	_____		_____		_____
BASEBALL	_____		_____		_____
BASKETBALL	_____		_____		_____
CHEERLEADING	_____		_____		_____
CROSS COUNTRY	_____		_____		_____
DRILL TEAM	_____		_____		_____
FIELD HOCKEY	_____		_____		_____
FOOTBALL (FALL)	_____		_____		_____
FOOTBALL (SPRING)	_____		_____		_____
GOLF	_____		_____		_____
GYMNASTICS	_____		_____		_____
ICE HOCKEY	_____		_____		_____
LACROSSE	_____		_____		_____
RODEO	_____		_____		_____
ROWING/CREW	_____		_____		_____
RUGBY	_____		_____		_____
SKIING	_____		_____		_____
SOCCER	_____		_____		_____
SOFTBALL	_____		_____		_____
STUDENT MANAGERS	_____		_____		_____
STUDENT TRAINERS	_____		_____		_____
SWIMMING/DIVING	_____		_____		_____
TENNIS	_____		_____		_____
TRACK & FIELD	_____		_____		_____
VOLLEYBALL	_____		_____		_____
WATER POLO	_____		_____		_____
WRESTLING	_____		_____		_____
OTHER (LIST)	_____		_____		_____
_____	_____		_____		_____
_____	_____		_____		_____
_____	_____		_____		_____
TOTALS	_____		_____		_____

PART B – AFFILIATION

NCAA I NCAA II NCAA III NAIA NJCAA OTHER _____

PART C – PREVIOUS INSURANCE INFORMATION

Begin with most recent insurance information

	Current year	Previous year	Previous year	Previous year
BENEFITS				
Medical Maximum Limit				
Excess or Primary				
Deductible				
Benefit Period				
Accident Death Benefit				
Coverage for overuse injuries/conditions				
Coverage for HMO/PPO denials				
Coverage for re-injury/re-aggravation				
Insurance Carrier				
PREMIUM				
Basic				
Catastrophic				
CLAIMS HISTORY**				
Number of Claims Paid				
Total Amount of Claims Paid				
As of (Month/Year)				

**PLEASE ATTACH CARRIER LOSS REPORTS FOR ALL YEARS DATED NO EARLIER THAN 12/31 of the current year.

PART D – OPTIONS

Deductible: \$0.00 \$250.00 \$500.00 \$1,000.00 Other \$ _____ Other \$ _____

Coverage for overuse injuries/conditions: Yes No

Coverage for HMO/PPO denials: Yes No

Coverage for re-injury/re-aggravation: Yes No

Accidental Death & Dismemberment Benefit: \$ _____

Quote for Catastrophic Coverage: Yes No

QUOTE NEEDED BY: _____

RETURN THIS COMPLETED FORM TO:

Specialty Insurance Solutions, Inc.

15621 W. 87th St. Pkwy., Suite 345

Lenexa, KS 66219

1-877-9-SIS INC (877-974-7462)/Fax 913-327-0201



**SPECIALTY
INSURANCE
SOLUTIONS**

"ONE COMPANY... MANY SOLUTIONS"