

RSC – Recognized Sports Clubs of the University of California Event Liability Insurance Registration Form

Phone: 866-838-9536

Fax: 515-365-3005

E-mail: plsdsteam.service@amba.info

Please complete all fields, any incomplete applications will be sent back to applicant.

Campus Name: _____

RSC Group Name: _____

Address: _____

City, State, Zip: _____

Website: _____

Contact Person Name (Billing): _____

Contact Phone #: _____ Contact Email address: _____

1. Date(s) of Event(s): _____

2. Where will the event be held? On Campus Off Campus

3. Location of Event(s):

a. Location Name: _____

b. Street Address 1: _____

c. Street Address 2: _____

d. City: _____

e. State: _____

f. Zip Code: _____

4. Complete description of event(s):

5. Provide the estimated number of Players/Participants/Campers: _____

6. Have all Players/Participants/Campers signed the required waivers? Yes No

7. Is this a Camp? Yes No

a. If this is a Camp, select one: Day Camp Overnight Camp

b. If this is an Overnight Camp, are minors (under 18) involved? Yes No

All Camps require further underwriting review, which may take up to 7-10 days.

The required Accident Medical Insurance for all Players/Participants/Campers is provided by the University of California for your group; review the Accident Medical Policy Summary for Club Sports coverage limits.

8. Are you required to provide proof of insurance to anyone other than the venue location provided above?

Yes No

If "Yes", provide the name of the Certificate Holder as it should appear on the Certificate of Insurance and the street address below. This is an entity that requires a copy of the Certificate of Insurance for proof of coverage.

- a. Certificate Holder Name: _____
- b. Street Address 1: _____
- c. Street Address 2: _____
- d. City: _____
- e. State: _____
- f. Zip Code: _____

9. Does an Additional Insured need to be listed on the Certificate? Yes No

Policy coverage is extended to this entity/individual upon request. This requires review by our underwriting team which may take 3-5 business days; for more immediate requests, please call us at 1-866-838-9536, Monday-Friday, 8am-5pm (CT).

a. If yes, is any special verbiage required on the Certificate by the Additional Insured? Yes No
If yes, provide specific verbiage or specific requirements below if requested.

Provide the name of the Additional Insured as it should appear on the Certificate of Insurance and the street address.

- b. Additional Insured Name: _____
- c. Street Address 1: _____
- d. Street Address 2: _____
- e. City: _____
- f. State: _____
- g. Zip Code: _____

Fraud Notice

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

In accordance with industry custom, Association Member Benefits Advisors (in California DBA: Association Member Benefits & Insurance Agency) is compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. These commissions are used to fund enrollments, ongoing servicing, billing, marketing, customer administrative and claim servicing, and communications. Our compensation may vary depending on the type of insurance purchased and the insurer selected.

Signing this Application shall not constitute a Binder or obligate the Company to provide this insurance, but it is agreed this Application shall be the basis on which a policy may be issued. Coverage will become effective upon approval of this Application and acceptable payment of premium.

Insured Signature

Date

Agent Signature

Date

CampusConnexions Program Administrator:
Association Member Benefits & Insurance Agency
P.O. Box 14521
Des Moines, IA 50306

CA Insurance License #0I96562