

Enrollment Form for Accident Medical Insurance Toughman Events

Underwritten by: 
Capitol Insurance Companies
Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

Please print or type.

[a] Name of Policyholder/Promoter _____

[b] Address _____ Phone _____
Street City State Zip

[c] Date of Event _____

[d] Plan of Benefits & Premium Rates (Check Plan Selected)

<i>Plan Number</i>	<i>Maximum Medical Benefit</i>	<i>Accidental Death Benefit</i>	<i>Deductible</i>	<i>Premium</i>
<input type="checkbox"/> 1	\$2,500.00	\$2,500.00	\$500.00	\$805.00
<input type="checkbox"/> 2	\$5,000.00	\$5,000.00	\$500.00	\$1,125.00
<input type="checkbox"/> 3	\$10,000.00	\$10,000.00	\$500.00	\$2,000.00
<input type="checkbox"/> 4	\$20,000.00	\$50,000.00	\$500.00	\$2,500.00
<input type="checkbox"/> 5	\$50,000.00	\$50,000.00	\$500.00	\$3,000.00

- All above premium rates are per 2-day event
- Policy to cover participants only
- Scope of coverage is full excess

[e] I understand and agree that if this enrollment form is accepted by the Company, coverage will begin on the date of acceptance or on the date requested in statement C (above), whichever is later, subject to the payment of the required premium.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files claim containing a false or deceptive statement is guilty of insurance fraud.

Policyholder _____

Title or Position _____ Date Signed _____

Agent/Broker Name & Address _____

Agent Phone _____

Boxing/Martial Arts Event Liability *Application Form*

Please print or type.

[a] Name of Policyholder/Promoter _____

[b] Address _____ Phone _____
Street City State Zip

[c] Is Policyholder A Corporation An Individual A Partnership Other LLC

[d] Name of Event _____

[e] Location of Event _____

[f] Date & Time _____ Seating Capacity _____ Estimated Attendance _____

[g] Liability Insurance Limits Requested \$1,000,000.00 Per Occurrence / \$2,000,000.00 Aggregate
 \$2,000,000.00 Per Occurrence / \$2,000,000.00 Aggregate
 \$3,000,000.00 Per Occurrence / \$3,000,000.00 Aggregate

[h] Have any of the Policyholder's/Promoter's past boxing insurance policies been cancelled or non-renewed in the past? If yes, please give details.

[i] Have any of the Policyholder's/Promoter's past boxing insurance policies had claims filed against them? If yes, please give details.

[j] Is the Policyholder/Promoter responsible for any of the following

- | | | |
|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Temporary Lighting | <input type="checkbox"/> Ushers | <input type="checkbox"/> Vendors |
| <input type="checkbox"/> Temporary Stage | <input type="checkbox"/> Security | <input type="checkbox"/> Concessions |
| <input type="checkbox"/> Tent | <input type="checkbox"/> Liquor | |

[k] Security provider for the event _____

[l] Fire Protection Proximity to Fire/Medical Services _____

Is Facility Protected By Sprinkler System Yes No

Are Fire Extinguishers Located at Facility Yes No

[m] List any Additional Insureds and relation to the applicant _____

Agent Address/Phone

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits application or files claim containing a false or deceptive statement may be guilty of insurance fraud.

Enrollment Form for Accident Medical Insurance Amateur & Professional Boxing & Wrestling Events

Underwritten by: **CAPITOL**
INSURANCE COMPANIES
Capitol Insurance Companies
Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

Please print or type.

[a] Name of Policyholder/Promoter _____

[b] Address _____ Phone _____
Street City State Zip

[c] Date of Event _____

[d] Type of Event Boxing Wrestling

[e] Plan of Benefits & Premium Rates (Check Plan Selected)

Plan Number	Maximum Medical Benefit	Accidental Death Benefit	Deductible	Premium
<input type="checkbox"/> 1	\$2,500.00	\$2,500.00	\$500.00	\$500.00
<input type="checkbox"/> 2	\$2,500.00	\$2,500.00	\$1,000.00	\$350.00
<input type="checkbox"/> 3	\$5,000.00	\$5,000.00	\$500.00	\$650.00
<input type="checkbox"/> 4	\$5,000.00	\$5,000.00	\$1,000.00	\$600.00
<input type="checkbox"/> 5	\$10,000.00	\$10,000.00	\$500.00	\$1,000.00
<input type="checkbox"/> 6	\$10,000.00	\$10,000.00	\$1,000.00	\$875.00
<input type="checkbox"/> 7	\$20,000.00	\$20,000.00	\$500.00	\$1,450.00
<input type="checkbox"/> 8	\$20,000.00	\$20,000.00	\$1,000.00	\$1,200.00
<input type="checkbox"/> 9	\$20,000.00	\$50,000.00	\$500.00	\$1,650.00
<input type="checkbox"/> 10	\$20,000.00	\$50,000.00	\$1,000.00	\$1,350.00
<input type="checkbox"/> 11	\$50,000.00	\$50,000.00	\$500.00	\$2,500.00
<input type="checkbox"/> 12	\$50,000.00	\$50,000.00	\$1,000.00	\$2,250.00

- All above premium rates are per event
- Limit 10 bouts per event
- All events are limited to 1 day
- Policy to cover participants only
- Scope of coverage is full excess

[f] I understand and agree that if this enrollment form is accepted by the Company, coverage will begin on the date of acceptance or on the date requested in statement C (above), whichever is later, subject to the payment of the required premium.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files claim containing a false or deceptive statement is guilty of insurance fraud.

Policyholder _____

Title or Position _____ Date Signed _____

Agent/Broker Name & Address _____

Agent Phone _____

Enrollment Form for Accident Medical Insurance Kickboxing/Mixed Martial Arts Wrestling Events

Underwritten by:  **CAPITOL**
INSURANCE COMPANIES
Capitol Insurance Companies
Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

Please print or type.

[a] Name of Policyholder/Promoter _____

[b] Address _____ Phone _____
Street City State Zip

[c] Date of Event _____

[d] Type of Event Kickboxing Mixed Martial Arts

[e] Plan of Benefits & Premium Rates (Check Plan Selected)

Plan Number	Maximum Medical Benefit	Accidental Death Benefit	Deductible	Premium
<input type="checkbox"/> 1	\$2,500.00	\$2,500.00	\$500.00	\$770.00
<input type="checkbox"/> 2	\$2,500.00	\$2,500.00	\$1,000.00	\$700.00
<input type="checkbox"/> 3	\$5,000.00	\$5,000.00	\$500.00	\$910.00
<input type="checkbox"/> 4	\$5,000.00	\$5,000.00	\$1,000.00	\$840.00
<input type="checkbox"/> 5	\$10,000.00	\$10,000.00	\$500.00	\$1,400.00
<input type="checkbox"/> 6	\$10,000.00	\$10,000.00	\$1,000.00	\$1,190.00
<input type="checkbox"/> 7	\$20,000.00	\$20,000.00	\$500.00	\$2,750.00
<input type="checkbox"/> 8	\$20,000.00	\$20,000.00	\$1,000.00	\$2,400.00
<input type="checkbox"/> 9	\$20,000.00	\$50,000.00	\$500.00	\$3,000.00
<input type="checkbox"/> 10	\$20,000.00	\$50,000.00	\$1,000.00	\$2,650.00
<input type="checkbox"/> 11	\$50,000.00	\$50,000.00	\$500.00	\$4,250.00
<input type="checkbox"/> 12	\$50,000.00	\$50,000.00	\$1,000.00	\$4,000.00

- All above premium rates are per event
- **Limit 20 Participants per Event — (Larger Events Must Be Submitted for a Quotation.)**
- All events are limited to 1 day
- Policy to cover participants only
- Scope of coverage is full excess

[f] I understand and agree that if this enrollment form is accepted by the Company, coverage will begin on the date of acceptance or on the date requested in statement C (above), whichever is later, subject to the payment of the required premium.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files claim containing a false or deceptive statement is guilty of insurance fraud.

Policyholder _____

Title or Position _____ Date Signed _____

Agent/Broker Name & Address _____

Agent Phone _____