



VOLLEYTOTZ QUOTE INSURANCE WORKSHEET FOR:
Yearly Tots Coverage for Tournaments/Clinics/Practice

NOTE: PLEASE ATTACH PRACTICE SITES, DATES, AND ADDRESSES ON PAGE 3

LEAGUE, CLUB OR ORGANIZATION NAME _____

CONTACT NAME AND CELL PHONE NUMBER: _____

CONTACT EMAIL ADDRESS: _____

LEAD INSTRUCTOR NAME _____

PROGRAM NAME (VOLLEYTOTS, TOTS, VOLLEYKIDS, ETC.) _____

Attach additional sheet if necessary.

SECTION 1

LIABILITY: Carrier– Surplus Lines Carrier Rated A+ VIII (Superior) by AM Best

Occurrence	\$ 1,000,000	Aggregate	\$ 3,000,000
Fire Damage	\$ 100,000	Products/Completed Operations	INCLUDED
Personal/Advertising	\$ 1,000,000	Spectator Medical Expense	\$ 1,000

Physical/Sexual Abuse Option - EXCLUDED (Can be added for separate premium upon approval)
Non-Owned Auto Option – EXCLUDED (Can be added for separate premium upon approval)
Sports Equipment Option - EXCLUDED (Can be added for separate premium upon approval)
Policy Term – Limited to Dates of League Play

SECTION 2

EXCESS ACCIDENT: Carrier – The Hartford - Atlanta, GA

Excess Accident Limit	\$25,000	AD&D	\$2,500
Deductible	\$ 100	Dental	\$1,500

Policy Term – Limited to Dates of League Play

Any administrative fees added have been applied to the rates above.

SPORT	AGE	# OF PLAYERS	X	RATE PER PLAYER	TOTAL
VOLLEYTOTZ LEAGUE	Youth 3-11		X	\$8.00	

TOTAL LIABILITY PREMIUM \$ _____

SECTION 3

TOTALS: - All bolded lines must be completed.

A) LIABILITY PREMIUM AND ACCIDENT SECTION 1 & 2	\$ _____	(\$375.00 Minimum)
B) POLICY FEE	\$ 25.00	
C) TOTAL ESTIMATED DUE (Add lines A through B)	\$ _____	

SECTION 4

Payment Options: (Made payable to: ASC, money order or cashiers check. Please contact Barbara Cowin 817-545-4551 x18 if you would like to pay by credit card, a \$10 rush fee will apply to all credit card transactions)

I AM ENCLOSING:

- Full Payment for EXACT Participants recorded above.
- Full Payment for ESTIMATED Premium recorded above. An Audit form will be needed to report exact exposure on a monthly basis. A \$15.00 processing fee will be assessed at the time of the Audit. No Return Premium will be submitted so please calculate your estimate as close as possible. (WE DO NOT ACCEPT DEPOSIT PREMIUMS, YOU MUST PAY BASED ON AT LEAST YOUR ESTIMATED EXPOSURE)

****The rates quoted on this worksheet are based on an “average” policy with no optional coverages added. If you desire additional coverages or if your application, once submitted, indicates anything that may require additional premium(s) you will be notified immediately. ****

Coverage will be provided for tournament dates that are requested, approved, and premiums collected. If you apply for a current tournament and it is covered by these policies and then add another tournament during the policy term, but do not report those tournament dates nor pay a premium, that tournament IS NOT covered.



Insured signature: _____

Name/Title/Date

Please fill out this form, print and fax to Barbara Cowin: 817-545-4557 or email to bcowin@ascvb.com
For additional information please call John Sample 214-202-8446

Final Quote will be returned within 24 hours.

**REMIT THIS WORKSHEET WITH THE APPLICATION AND PREMIUM;
PLEASE CONTACT US IF ADDITIONAL COVERAGES ARE DESIRED.**