1712 Magnavox Way P.O. Box 2338
Fort Wayne, IN 46801-2338
(800) 441-3994 / (260)459-5588
Fax (260) 459-5120 CA# 0334819
www.kandkinsurance.com

CLUB/INTRAMURAL SPORTS ONLY
BASIC MEDICAL INSURANCE PROGRAM
QUOTATION REQUEST FORM

Name of School:______________________________

Web Site:______________________________

Mailing Address:______________________________

City:____________________ State: ____________ Zip:__________

Information Provided By:____________________ Title:__________

Phone:__________ Fax: __________ E-mail Address:__________

Sports Sanctioning Body:____________________ Division:__________

NUMBER OF PARTICIPANTS

	Men	Women		Men	Women		Men	Women
ARCHERY	______	______	GOLF	______	______	SWIM/DIVE	______	______
BADMINTON	______	______	GYMNASTICS	______	______	TENNIS	______	______
BAND	______	______	ICE HOCKEY	______	______	TRACK & FIELD	______	______
BASEBALL	______	______	KARATE/JUDO	______	______	VOLLEYBALL	______	______
BASKETBALL	______	______	LACROSSE	______	______	WATER POLO	______	______
BOWLING	______	______	RIFLE	______	______	WRESTLING	______	______
BOXING	______	______	RODEO	______	______	OTHERS (LIST)		
CHEERLEADERS	______	______	ROWING/CREW	______	______	______________	______	______
CROSS COUNTRY	______	______	RUGBY	______	______	______________	______	______
CYCLING	______	______	SAILING	______	______	______________	______	______
EQUESTRIAN	______	______	SKIING	______	______	______________	______	______
FENCING	______	______	SOCCER	______	______	______________	______	______
FIELD HOCKEY	______	______	SOFTBALL	______	______	______________	______	______
FOOTBALL, FALL	______	______	STUDENT MANAGERS	______	______	______________	______	______
FOOTBALL, SPRING	______	______	SQUASH/RACQUETBALL	______	______	______________	______	______

1. PREVIOUS INSURANCE INFORMATION: Please provide copies of claim reports from your prior insurance carrier(s).

	Three Years Prior	Two Years Prior	One Year Prior	Current Year
Maximum Medical Coverage	$	$	$	$
Excess or Primary				
Deductible	$	$	$	$
Full Coverage for Pre-Existing Conditions	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Full Coverage for HMO/PPO Denials	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Benefit Period Limit				
Accidental Death Maximum Limit	$	$	$	$
Premium	$	$	$	$
Number of Claims Paid				
Benefits Paid	$	$	$	$
as of (Date)				
Name of Insurer				

2. RISK MANAGEMENT INFORMATION:

Certified athletic trainer(s) on staff? ❑ Yes ❑ No

If yes, for which sports is trainer responsible?______________________________

____

Team Physician: ❑ On Staff ❑ On Retainer ❑ Other (please describe)______________________________

____

Physician's Specialty:______________________________

Is physician board certified? ❑ Yes ❑ No

Does the athletic department or coaching staff routinely:

Obtain information about athlete's other insurance coverage? ❑ Yes ❑ No

Require pre-participation physical examination? ❑ Yes ❑ No

If yes, for which sports?______________________________

____

Type of institution? ❑ Public ❑ Private

Type of surface where activities take place? ❑ Artificial ❑ Grass

What other activities take place on this surface?______________________________

____

Does your institution have a medical school which provides care at no cost to the athletes? ❑ Yes ❑ No

What percentage of your student athletes have primary medical coverage?______________________________

This is not an offer of coverage nor an application for insurance. Requests for coverage will be subject to company underwriting standards. Actual coverage terms will be described in a policy of insurance if one is issued.

I understand that the insurance company in determining whether to provide a quotation for insurance coverage will rely on the information contained in the form and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

______________________________ ______________________________

Applicant's Signature Producer's Signature (if applicable)

______________________________ ______________________________

Applicant's Name (print) Producer's Name (print)

______________________________ ______________________________

Date (MM/DD/YY) Date (MM/DD/YY)

Please mail or fax both sides of this form to:

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