

**BASIC INTERCOLLEGIATE/ATHLETIC ACCIDENT INSURANCE PROGRAM  
 QUOTATION REQUEST FORM  
 INTERCOLLEGIATE SPORTS ONLY**

NAME OF SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

INFORMATION PROVIDED BY: \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
Name Title Phone #

SPORTS SANCTIONING BODY: \_\_\_\_\_ DIVISION: \_\_\_\_\_

New  Renewal

<u>SPORT</u>	<u>NUMBER OF PARTICIPANTS</u>			<u>SPORT</u>	<u>NUMBER OF PARTICIPANTS</u>		
	<u>MEN</u>	<u>WOMEN</u>	<u>TOTAL</u>		<u>MEN</u>	<u>WOMEN</u>	<u>TOTAL</u>
ARCHERY	_____	+ _____	= _____	RIFLE	_____	+ _____	= _____
BADMINTON	_____	+ _____	= _____	RODEO	_____	+ _____	= _____
BAND	_____	+ _____	= _____	ROWING/CREW	_____	+ _____	= _____
BASEBALL	_____	+ _____	= _____	RUGBY	_____	+ _____	= _____
BASKETBALL	_____	+ _____	= _____	SAILING	_____	+ _____	= _____
BOWLING	_____	+ _____	= _____	SKIING	_____	+ _____	= _____
BOXING	_____	+ _____	= _____	SOCCER	_____	+ _____	= _____
CHEERLEADING	_____	+ _____	= _____	SOFTBALL	_____	+ _____	= _____
CROSS COUNTRY	_____	+ _____	= _____	STUDENT MANAGERS	_____	+ _____	= _____
CYCLING	_____	+ _____	= _____	SQUASH	_____	+ _____	= _____
EQUESTRIAN	_____	+ _____	= _____	SWIM/DIVE	_____	+ _____	= _____
FENCING	_____	+ _____	= _____	TENNIS	_____	+ _____	= _____
FIELD HOCKEY	_____	+ _____	= _____	TRACK & FIELD	_____	+ _____	= _____
FOOTBALL, FALL	_____	+ _____	= _____	VOLLEYBALL	_____	+ _____	= _____
FOOTBALL, SPRING	_____	+ _____	= _____	WATER POLO	_____	+ _____	= _____
GOLF	_____	+ _____	= _____	WRESTLING	_____	+ _____	= _____
GYMNASTICS	_____	+ _____	= _____	OTHERS (LIST)	_____	+ _____	= _____
ICE HOCKEY	_____	+ _____	= _____	_____	_____	+ _____	= _____
KARATE/JUDO	_____	+ _____	= _____	_____	_____	+ _____	= _____
LACROSSE	_____	+ _____	= _____	_____	_____	+ _____	= _____
RACQUETBALL	_____	+ _____	= _____	_____	_____	+ _____	= _____

**TOTAL # OF PARTICIPANTS =** \_\_\_\_\_

**DECISION CRITERIA**

Please indicate your decision criteria for the intercollegiate sports plan. Rate the following (1-6):

- Price \_\_\_\_\_
- Claims Handling \_\_\_\_\_
- Company Rating/Financial Stability \_\_\_\_\_
- Local Representation \_\_\_\_\_
- Service \_\_\_\_\_
- Other: \_\_\_\_\_

Please briefly explain your decision criteria: \_\_\_\_\_



1437 Seventh Street, Suite 400  
 Santa Monica, CA 90401

POLICY EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PROPOSAL RENEWAL DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

	2008/2009	2009/2010	2010/2011
Name of Insurer			
Maximum Medical Coverage	\$	\$	\$
Excess or Primary			
Deductible Amount	\$	\$	\$
Full Coverage for Pre-Existing Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Full Coverage for HMO/PPO Denials	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Circulatory Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extended Claims Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Expanded Medical Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Guest/Recruit Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit Period Limit			
Premium Amount	\$	\$	\$
Number of Claims Paid			
Benefits Paid: Amount	\$	\$	\$
Through Date (Mo/Yr)			

**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: \_\_\_\_\_

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? \_\_\_\_\_

**GENERAL QUESTIONS:**

1. What do you like best about your present sports plan and insurance carrier? \_\_\_\_\_

2. If there was anything you could change about the plan or insurance company, what change(s) would you make? \_\_\_\_\_

3. What is the administration's policy for student athletes? Are student athletes required to have medical coverage to participate in any athletic event(s)? \_\_\_\_\_

4. Please explain any other important issues you wish to discuss. \_\_\_\_\_

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.

Please fax both sides of this form to **Renaissance Insurance Agency, Inc.** at (310) 394-0142 or mail to our offices at the address on the front of this form.