

# SADLER

## **SPORTS & RECREATION INSURANCE**

PO Box 5866, Columbia, SC 29250-5866

Phone (800)622-7370 Fax (803)256-4017

Email [amateur@sadlersports.com](mailto:amateur@sadlersports.com)

March 1, 2009

**TO: AMATEUR YOUTH SPORTS CAMP/CLINIC INSURANCE COORDINATOR**

**RE: 2009/2010 SPORTS SEASON / ACCIDENT & GENERAL LIABILITY INSURANCE  
SPORTS, LEISURE AND ENTERTAINMENT RISK PURCHASING GROUP  
POLICY #: RPG44721**

Please keep in mind that you only have coverage for the camps and camp dates that you have indicated on your original application.  
**A CAMP BROCHURE IS REQUIRED FOR EACH CAMP.**

**A COMPLETED AUDIT FORM, AND ANY ADDITIONAL PREMIUM DUE, IS DUE WITHIN 30 DAYS OF THE LAST DAY OF THE CAMP.**

### **PROCEDURES TO FILE A CLAIM**

The attached claim form should be given to the parents and/or the claimant by the insurance coordinator.

The insurance coordinator must complete the bottom of the claim form. **\*\*\*NOTE\*\*\*** #1 on the bottom portion should have the name of the team and/or league. This information will be found on the certificate of insurance in the upper left hand corner, in the box marked "Insured". (PLEASE MAKE SURE THIS PORTION IS COMPLETED IN ITS ENTIRETY.)

### **ATTENTION PARENTS**

Please be advised that this coverage is EXCESS/secondary to any other valid and collectible coverage subject to a \$100.00 deductible. This means that if there is other health and accident coverage, all charges must be submitted to them first on a primary basis. This coverage will consider the amount not covered by the other insurance. If you have other coverage, the other carrier's payment(s) will be used to satisfy our deductible. If you have no other coverage we will apply the \$100 deductible to the charges received until the deductible has been satisfied. (**\*\*\*NOTE\*\*\*** Coverage is in effect for 52 weeks from the date of the accident.)

**\*\*\*NOTE\*\*\*** *If your other insurance is an HMO Plan, we recommend that you go to the providers within that plan. If you elect not to go to the providers within that plan the HMO may deny your claim and you would be responsible for the deductible under the league insurance plan.*

Please make sure the insurance coordinator has completed the lower portion of the claim form in its entirety. The parent/guardian will need to complete the upper portion of this form in its entirety. Omission of any information may cause a delay in the processing of your claim.

Please attach all itemized billings, along with the corresponding explanation of benefits from your other insurance showing what they paid. K&K Insurance Group will then process the outstanding portion. If there are any questions concerning the filing of a claim, you may contact K&K at 1-800-237-2917.

**FORWARD THE COMPLETED CLAIM FORM AND ATTACHMENTS TO:**

**K&K Insurance Group, Inc. - Claims Department  
P O Box 2338, Ft. Wayne, IN 46801**

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**YOUTH SPORTS CAMP/CLINIC INSURANCE PROGRAM / ADD CAMPS AND AUDIT REPORT FORM  
2009 / 2010 POLICY #: RPG44721**

**Named insured (as it should appear on the policy):** *(the legal name of the organization; typically the name that would appear on any contracts or agreements)*

Doing business as (DBA): *(additional names(s) under which the named insured operates)*

Home Phone: (     )

Contact Name:

Daytime Phone: (     )

Mailing Address:

Fax #: (     )

City:

State:

Zip:

**SIGNATURE OF AUTHORIZED OFFICIAL:**

**TITLE:**

**OPTION A - (Minimum Premium is \$240 for this Option)**

**RATE**

\$1,000,000	General Liability	Clinics	\$1.33 Per Participant/Per Day
\$1,000,000	Participant Legal Liability	Day Camps	\$4.00 Per Participant/Per Week
\$ 25,000	Medical Payments For Participants	Overnight Camps	\$5.32 Per Participant/Per Week
\$ 1,000	Medical Expense Reimbursements for Illness		<i>A week is 3 to 7 consecutive days.</i>

**OPTION B - (Minimum Premium is \$360 for this Option)**

**RATE**

\$2,000,000	General Liability	Clinics	\$1.82 Per Participant/Per Day
\$2,000,000	Participant Legal Liability	Day Camps	\$5.54 Per Participant/Per Week
\$ 250,000	Medical Payments For Participants	Overnight Camps	\$7.35 Per Participant/Per Week
\$ 1,000	Medical Expense Reimbursements for Illness		<i>A week is 3 to 7 consecutive days.</i>

**CHECK ONE:**  **ADD CAMP DATES**       **AUDIT REPORT FOR PREVIOUS CAMPS**

(New camp dates must be reported in advance and a camp brochure must be submitted with request.)

OPTION A OR B	SPORT	LIST ALL SESSION DATES	AGE GROUP	# PARTICIPANTS	X	RATE	=	PREMIUM
					X	\$	=	\$
					X	\$	=	\$
					X	\$	=	\$
					X	\$	=	\$

*ATTACH SEPARATE SHEET IF NECESSARY*

**SUBTOTAL or MINIMUM PREMIUM:** \$

**TOTAL ACTUAL PREMIUM DUE** \$

**SUBTRACT PREMIUM PAID WITH ORIGINAL ENROLLMENT FORM** -(\$     )

**Total Premium Due (A):** \$     (A)

**Florida applicants must add 1% to total premium due [1% x subtotal (A)] = Florida assessment fee:** \$     (B)

**Total amount due for FLORIDA APPLICANTS [total premium due (A+B=C)]:** \$     (C)

**ADDITIONAL PREMIUM DUE NOW:** (\$     )

**REFUND DUE TO ORGANIZATION:** (\$     )

- ◆ **ROSTER OF CAMPER NAMES MUST BE INCLUDED**
- ◆ **REFUNDS ARE NOT AVAILABLE IF THE MINIMUM PREMIUM WAS PAID.**
- ◆ **REFUNDS WILL NOT HONORED IF RECEIVED LATER THAN 30 DAYS FOLLOWING THE END OF YOUR CAMP/CLINIC SESSIONS REPORTED ON YOUR ORIGINAL ENROLLMENT FORM**

**MAIL THIS COMPLETED CAMP-CLINIC AUDIT FORM TO:**

If you would like to send your **AUDIT REPORT** & check via **U S Mail**, please send to:  
Sadler & Company, Inc.  
P. O. Box 5866  
Columbia, SC 29250-5866

If you would like to send your **AUDIT REPORT** & check via **overnight delivery**, please send to:  
Sadler & Company, Inc.  
3014 Devine Street, 2<sup>nd</sup> Floor  
Columbia, SC 29205