



**Texas Specialty Underwriters, Inc.**  
 510 Turtle Cove Blvd., Suite 200  
 Rockwall, Texas 75087  
 Voice (972) 771-5653 Fax (972) 722-5392 Watts (800) 442-7050

## Sports Camps/Clinics/Leagues General Liability Application

Applicant's Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 \_\_\_\_\_  
 Location \_\_\_\_\_  
 \_\_\_\_\_

Agent Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Agent No. \_\_\_\_\_

**PROPOSED EFFECTIVE DATE:**

From \_\_\_\_\_ To \_\_\_\_\_  
**12:01 A.M., Standard Time at the address of the Applicant**

LIMITS OF LIABILITY REQUESTED		PREMIUMS
General Aggregate	\$	Premises/Operations
Products & Completed Operations Aggregate	\$	
Personal & Advertising Injury	\$	Products/Completed Operations
Each Occurrence	\$	
Fire Damage (any one fire)	\$	Other
Medical Expense (any one person)	\$	
Other Coverages, Restrictions, and/or Endorsements		Total
Deductible \$		\$

PLEASE ANSWER ALL QUESTIONS-IF THEY DO NOT APPLY, INDICATE NOT APPLICABLE

### APPLICANT PREMISES OPERATIONS INFORMATION

#### SECTION I SPORTS CAMPS QUESTIONNAIRE (see Section 2 for Youth Leagues & Clinics)

1. Name of camp (if different than Applicant): \_\_\_\_\_
2. Day camp opens: \_\_\_\_\_ closes: \_\_\_\_\_
3. Years in business: \_\_\_\_\_ Under present ownership: \_\_\_\_\_
4. Applicant is:  Individual  Corporation  Joint Venture  Other (Specify): \_\_\_\_\_
5. Is the camp accredited by A.C.A.?  Yes  No
6. Is the camp a member of another camping association?  Yes  No If yes, which one(s)? \_\_\_\_\_
7. The camp is:  Coed  Boys  Girls  Adults
8. The camp is a-  Day Camp  Resident Camp  Travel Camp
9. It is:  Private  Nonprofit  Agency  Religious

**PREMIUM BASIS**

10. Estimated number of campers per day: \_\_\_\_\_

11 . How many days per week? \_\_\_\_\_ Weeks per year? \_\_\_\_\_

**UNDERWRITING CRITERIA**

12. Age range of campers: \_\_\_\_\_

13. Total number of employees: \_\_\_\_\_

14. What is the ratio of counselors to campers? \_\_\_\_\_

15. Does the applicant have accident and health coverage on the campers?  Yes  No If yes, who is the carrier and what are the limits of liability? \_\_\_\_\_

16. Any hold harmless agreements?  Yes  No If yes, with whom and what is the nature of the agreement? \_\_\_\_\_

17. Does the camp specialize in camping experiences for developmentally disabled individuals?  Yes  No If yes, please provide a narrative of such program below or on a separate sheet, if necessary. \_\_\_\_\_

18. List the locations of the facilities where the camps are being held: \_\_\_\_\_

19. Describe all activities the campers will be involved in during the duration of their stay: \_\_\_\_\_

20. If the campers are participating in activities away from the camp, what is the mode of transportation and what arrangements are made to transport the participants? \_\_\_\_\_

21. List the complete names and addresses of the facilities which have requested being named as an additional insured on the policy: \_\_\_\_\_

**LOSS HISTORY**

Previous Insurer: Indicate premium and losses for the past three years. Describe all losses.

YEAR	COMPANY	POL. #	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

If the questions for Section 2 Youth Leagues and Clinics do not apply, please turn to the last page, read the fraud warnings and sign and date the application.

**SECTION 2 YOUTH LEAGUES AND CLINICS QUESTIONNAIRE**

1. **Name of the league or clinic** (if different than Applicant): \_\_\_\_\_
2. **Name and address of the sponsor:** \_\_\_\_\_  
\_\_\_\_\_
3. **Is the premises or playing field owned by the Applicant?**  Yes  No If yes, what is the size and use of the premises, number of fields, and owned equipment on the premises? (Example, bleachers, nets, courts and goals)  
\_\_\_\_\_
4. **Years in business:** \_\_\_\_\_
5. **Applicant is:**  Individual  Corporation  Joint Venture  Other (Specify): \_\_\_\_\_
6. **Number of coaches:** \_\_\_\_\_ If they are accredited, by whom? \_\_\_\_\_  
\_\_\_\_\_
7. **Do the coaches carry their own insurance?**  Yes  No If yes, who is the carrier and what are the limits of liability?  
\_\_\_\_\_
8. **Is the league or clinic a member of an association?**  Yes  No If yes, which one(s)? \_\_\_\_\_  
\_\_\_\_\_
9. **The league or clinic is:**  Coed  Boys  Girls  Adults
10. **The sports league or clinic is for:**  Baseball  Basketball  Softball  Archery  Tennis  
 Volleyball  Bowling  Running or cross country hiking

**PREMIUM BASIS**

11. **The number of participants at the clinic is:** \_\_\_\_\_ The number of days for the clinic is: \_\_\_\_\_
12. **The total number of games for the sports league for the season is:** \_\_\_\_\_
13. **The number of traveling tournaments is:** \_\_\_\_\_

**UNDERWRITING CRITERIA**

14. **Age of the participants is:** \_\_\_\_\_
15. **Total number of employees:** \_\_\_\_\_
16. **What is the ratio of supervisors to participants?** \_\_\_\_\_
17. **Does the applicant have accident and health coverage on the participants?**  Yes  No If yes, who is the carrier and what are the limits of liability?  
\_\_\_\_\_  
\_\_\_\_\_
18. **Any hold harmless agreements?**  Yes  No If yes, with whom and what is the nature of the agreement?  
\_\_\_\_\_  
\_\_\_\_\_
19. **Does the clinic or league specialize in workshops or games for developmentally disabled individuals?**  
 Yes  No If yes, please provide a narrative of such program below or on a separate sheet, if necessary. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. If they participate in traveling tournaments, what is the mode of transportation and what arrangements are made to transport the participants? \_\_\_\_\_
21. What safety equipment is required to be worn by the participants and are they advised to its proper use? \_\_\_\_\_
22. List the locations of the facilities where the games are being held: \_\_\_\_\_
23. List the complete names and addresses of the facilities which have requested being named as an additional insured on the policy: \_\_\_\_\_
24. Do they have a snack bar, sports shop, or other retail business?  Yes  No If yes, describe and indicate the estimated gross sales: \_\_\_\_\_

**LOSS HISTORY**

Previous insurer: Indicate premium and losses for the past three years. Describe all losses.

YEAR	COMPANY	POL. #	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

**APPLICABLE IN THE STATE OF NEW YORK:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**FRAUD WARNING:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 (MUST BE OWNER, PARTNER OR OFFICER)

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT

**IMPORTANT NOTICE**

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.