

**Maximum Medical \$25,000 ♦ Deductible \$250.00****Excess Coverage-52 Week Benefit Period****Wisconsin Track Coaches Association**

Name of Event: \_\_\_\_\_

Address: \_\_\_\_\_

Location of Event: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_ Termination date of coverage: \_\_\_\_\_

# of Participants: \_\_\_\_\_ # of Days: \_\_\_\_\_ # of Coaches/Volunteers \_\_\_\_\_ Sport \_\_\_\_\_

# of Participants: \_\_\_\_\_ # of Days: \_\_\_\_\_ # of Coaches/Volunteers \_\_\_\_\_ Sport \_\_\_\_\_

# of Participants: \_\_\_\_\_ # of Days: \_\_\_\_\_ # of Coaches/Volunteers \_\_\_\_\_ Sport \_\_\_\_\_

Optional Catastrophic Medical Limit: \$300,000 Deductible \$25,000  Yes  NoPrior Insurance History: Prior Coverage  Yes  No

Name of Carrier: \_\_\_\_\_

_____	_____	_____
Year	Premium Paid	Losses Paid
_____	_____	_____
Year	Premium Paid	Losses Paid
_____	_____	_____
Year	Premium Paid	Losses Paid

Signed Statement: \_\_\_\_\_

The above information is correct to the best of my knowledge. I understand the company must approve my request form before coverage is effective. Coverage is not bound until payment is received.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

For a quotation, please fax to Loomis & LaPann, Inc. 518-792-3426 Attention: Greg Joly; Kevin Joyce or Karen Boller  
Inquiries to Greg; Kevin or Karen @ 800-566-6479 or email:[gjoly@loomislapann.com](mailto:gjoly@loomislapann.com)[kjoyce@loomislapann.com](mailto:kjoyce@loomislapann.com)[kboller@loomislapann.com](mailto:kboller@loomislapann.com)

Rating completed by Loomis &amp; LaPann, Inc.

# of Participants \_\_\_\_\_ x days \_\_\_\_\_ x rate \_\_\_\_\_ = Premium \_\_\_\_\_

Minimum premium \$250.