

# N.O.C.A.D

## PARTICIPANT / ACCIDENT REQUEST FORM

Maximum Medical \$25,000 ♦ Accidental Death \$5,000 ♦ Deductible \$250.00

Excess Coverage-52 Week Benefit Period

### Indiana Basketball 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  No

Prior Insurance History: Did you have 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 @ 800-566-6479 or email:

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Rating completed by Loomis & LaPann, Inc.

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

Minimum premium \$250