

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 Football 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:

gjoly@loomislapann.com kjoyce@loomislapann.com kboller@loomislapann.com

Rating completed by Loomis & LaPann, Inc.

of Participants _____ x days _____ x rate _____ = Premium _____

Minimum premium \$250