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 High School Baseball 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_______

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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
___________	________________	_________________
___________	________________	_________________
___________	________________	_________________

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