POLICY CHANGE REQUEST

This form is to be completed and e-mailed or faxed to your insurance agent. Corrected policy documents will be provided within 48 hours. Please note that changes may be subject to remittance of additional premium.

Name of policyholder _____

Liability certificate number _____

Accident policy number _____

Name of policyholder *and* the general liability certificate number or accident insurance policy number are required to process a change. Failure to include this information will create delays.

General information

Name correction

Correct the policyholder name to _____

Date correction

Correct the effective and termination date to: ____ ____ ____ through ____ ____ ____

month day year month day year

Adjust Number of Participants, Teams or Other Exposure Base

Add	Remove	Change To	
☐	☐	☐	_____
☐	☐	☐	_____
☐	☐	☐	_____

Coverage Addition / Removal

The following coverages should be added / removed:

General Liability Insurance

Add	Remove	
☐	☐	$5,000.00 Medical Payments
☐	☐	$150,000.00 Hired and Non-Owned Automobile Liability Coverage
☐	☐	$500,000.00 Hired and Non-Owned Automobile Liability Coverage
☐	☐	$1,000,000.00 Hired and Non-Owned Automobile Liability Coverage
☐	☐	$100,000.00 Sexual Abuse and Molestation Liability Coverage
☐	☐	$2,000,000.00 General Aggregate
☐	☐	$3,000,000.00 General Aggregate
☐	☐	$4,000,000.00 General Aggregate
☐	☐	$5,000,000.00 General Aggregate
☐	☐	$1,000,000.00 Liquor Liability Coverage

Accident Insurance

Add	Remove	
☐	☐	$25,000.00 Maximum Medical Expense Benefit
☐	☐	$50,000.00 Maximum Medical Expense Benefit
☐	☐	$100,000.00 Maximum Medical Expense Benefit

Other or Additional Details of Policy Change Request

_____

_____

_____

_____

_____

_____

_____ _____ _____

Policyholder Signature E-Mail Address FAX Number

REQUEST FOR ADDITIONAL INSURED

Name, full mailing address and relationship are required to add additional insureds.

Additional Insured Entity #1

Name: _____

Mailing Address: _____

_____

_____

Required Additional Insured Wording: _____

_____

_____

Relationship:
- ☐ Landlord
- ☐ Venue
- ☐ Event Operator
- ☐ Franchisor/Franchise Owner
- ☐ Independent Contractor (requires $75 additional premium)
- ☐ Other (specify) _____
- ☐ Add Primary and Non-Contributory Clause (requires $100 additional premium)
- ☐ Add Waiver of Subrogation (requires $100 additional premium)

Additional Insured Entity #2

Name: _____

Mailing Address: _____

_____

_____

Required Additional Insured Wording: _____

_____

_____

Relationship:
- ☐ Landlord
- ☐ Venue
- ☐ Event Operator
- ☐ Franchisor/Franchise Owner
- ☐ Independent Contractor (requires $75 additional premium)
- ☐ Other (specify) _____
- ☐ Add Primary and Non-Contributory Clause (requires $100 additional premium)
- ☐ Add Waiver of Subrogation (requires $100 additional premium)

Additional Insured Entity #3

Name: _____

Mailing Address: _____

_____

_____

Required Additional Insured Wording: _____

_____

_____

Relationship:
- ☐ Landlord
- ☐ Venue
- ☐ Event Operator
- ☐ Franchisor/Franchise Owner
- ☐ Independent Contractor (requires $75 additional premium)
- ☐ Other (specify) _____
- ☐ Add Primary and Non-Contributory Clause (requires $100 additional premium)
- ☐ Add Waiver of Subrogation (requires $100 additional premium)

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 may be a crime.

Applicant's Acknowledgement I, the applicant, declare, to the best of my knowledge and belief, that all statements and answers in this application are true and complete. I understand and agree that (a) this application will form part of any policy issued, (b) no information given to or acquired by any representative of the Company will bind it, unless it is in writing on this application, (c) no waiver or modification will bind the Company unless it is in writing and is signed by an executive officer of the Company, and (d) only those persons eligible under the terms of an issued policy will be insured.

Payment Information

Please complete the credit card payment information below:

Account Billing Address _____
Street City State Zip

Phone Number _____ **E-mail Address** _____

☐ **Please charge my:** ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Cardholder Name _____

Card # _____

Exp. Date (mm/yyyy) _____

Security Code _____

A Convenience Fee of 3% will be added to Credit Card Transactions.

Payments will be processed by Francis L. Dean & Associates