



Amateur Sports Adult Soccer Teams, Leagues & Associations Supplemental Request Form

This supplemental is valid for effective dates from 3/1/26 through 2/28/27

Please retain a copy of this form for your records.

GENERAL
INFORMATION

Named insured (as it appears on your Member Certificate): _____
 Policy number (as it appears on your Member Certificate): _____
 Name of individual submitting request: _____
 Title/Relationship: _____
 Phone: (____) _____ Cell: (____) _____
 E-mail: _____

Notes:

- You must submit this request BEFORE the effective date needed.
- Coverage will be made effective the day after this request form and payment are received, or on a later date that you may specify.
- All participants are required to be reported. TBD numbers cannot be accepted.
- A current and complete roster with names and ages (ages only, no birthdates) of all participants is required to bind coverage. All participants must sign waivers.
- Coverage must follow the same Commercial General Liability coverage/limits currently provided with your policy.

Effective date needed: ____/____/____

IMPORTANT INFORMATION

ADDITIONAL PARTICIPANT PROGRAM RATES

Use these rates to figure out your premium on the next page.

Coverage Option	\$1,000,000 CGL Limit Rate per Participant	\$2,000,000 CGL Limit Rate per Participant	\$3,000,000 CGL Limit Rate per Participant	\$4,000,000 CGL Limit Rate per Participant	\$5,000,000 CGL Limit Rate per Participant
Option 1 Commercial General Liability with \$1,000,000 Legal Liability to Participants and \$10,000 Medical Payments for Participants	\$35.91	\$39.78	\$41.71	\$42.87	\$43.72
Option 2 Commercial General Liability with \$500,000 Legal Liability to Participants and Medical Payments for Participants Excluded	\$7.42	\$11.13	\$12.99	\$14.10	\$14.91
Option 3 Commercial General Liability Only Legal Liability to Participants and Medical Payments for Participants are both Excluded	\$5.18	\$7.77	\$9.07	\$9.84	\$10.41

Note: Rates include Limited Neurodegenerative Injury Coverage to Specified Players for Sports or Athletic Activities. If you did not purchase this coverage, adjustments will be made at the time of binding.

SEXUAL MISCONDUCT LIABILITY RATES

Use only if you were approved and purchased this optional coverage at the time of your original binding.

Option 1	Option 2	Option 3
\$1.30	\$1.24	\$1.04

ADDITIONAL PARTICIPANTS PREMIUM CALCULATION

Coverage Option 1, 2 or 3	Number of Players Age 18 and Over	+	Number of Players Age 16 to 17	=	Total Number of Players	x	Rate (see pg 1)	=	Program Premium Due
		+		=		x	\$	=	\$ (a)
Does your current policy include Sexual Misconduct Liability Coverage? ☐ Yes ☐ No If yes, you will need to include rating from the prior page for this coverage.									
Total Number of Players from Above:						x	Rate (see pg 1) \$	=	\$ (b)
Total Premium Due (Add lines a + b):								=	\$

Complete this section if you require additional certificates listing a facility, property owner, or similar third-party as an additional insured on your policy. Provide a separate request for each additional certificate needed.

Note: Please request all additional insureds needed for this policy term. Additional insureds from the expiring policy term will not be automatically renewed.

1. When is this certificate needed? : ____/____/____ This certificate is for: ☐ General Liability Coverage

2. What is the additional insured's relationship to you? ☐ Owner/manager/lessor of premises (facility or venue)

☐ Sponsor ☐ Co-promoter ☐ Other (please identify/explain): _____

NOTE: The certificate holder will automatically be an Additional Insured for an Owner/manager/lessor, Sponsor, or Co-Promoter relationship.

3. Certificate holder/additional insured name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

4. Does the certificate holder/additional insured require any special wording or endorsements? ☐ Yes ☐ No

If yes, check all that apply: ☐ CG2026 ☐ Primary/Noncontributory ☐ Waiver of subrogation ☐ Cancellation - ____ days

☐ Other (please explain): _____

NOTE: If you are not sure, please attach a copy of the insurance requirements/instructions you've received.

If applicable:

5. For specific events: Date(s) of event/activity: ____/____/____ to ____/____/____

Hours of event/activity: _____ A.M. ☐ P.M. ☐ to _____ A.M. ☐ P.M. ☐

Type of event/activity: _____ Name of event/activity: _____

Location of event/activity: _____

The most common delay in certificate processing is caused by providing incomplete or inaccurate names and/or instructions. Please check your request carefully before submitting.

CERTIFICATE REQUESTS

K&K Insurance Group, Inc. • P.O. Box 2338 • Fort Wayne, IN 46801-2338 • 1-800-426-2889 • Fax 1-260-459-5105
www.kandkinsurance.com

K&K Insurance Group, Inc. is a licensed insurance producer in all states (TX license #13924); operating in CA, NY and MI as K&K Insurance Agency (CA license #0334819). K&K is acting as a Managing General Agent as that term is defined in section 626.015(14) of the Florida Insurance Code. As an MGA we are acting on behalf of our carrier partner.

FINAL PAYMENT CALCULATION AND PAYMENT OPTIONS

Step 1: Applicant business name from page 1: _____

Step 2: Enter additional participants premium from page 2: \$ _____ (a)

Step 3: Calculate surplus lines/stamping/transaction fees – this is based on the Named Insured's state on their Member Certificate.

NOTE: If your state is not specifically listed, use the last column labeled "All Other States". All states must calculate a surplus lines/stamping/transaction fee.

Insured's State	HI	IL	MI	MT	NV	NY	OK	UT	WY	All Other States
Surplus Line Tax	.0468	.035	.025	.0275	.035	.036	.06	.0425	.03	.025
Stamping/Transaction Fee	N/A	.0004	N/A	N/A	.004	.0015	.00175	.0018	.00175	N/A
FINAL STATE RATE	.0468	.0354	.025	.0275	.039	.0375	.06175	.0443	.03175	.025

Premium from Step 2 - \$ _____ (a) x **Final State Rate** from chart above \$ _____ = \$ _____ (b)

Step 4: TOTAL COST (Add lines a + b): \$ _____

Step 5: Select payment option:

☐ ACH – This option is only available for purchases made 15 days or more prior to the effective date.
Proceed to the next page to complete the ACH payment.

☐ Mail in check – Make check payable to K&K Insurance Group.

Regular: K&K Insurance
Soccer RPG Prog
P.O. Box 2338
Fort Wayne, IN 46801-2338

Overnight: K&K Insurance
Soccer RPG Prog
1690 Broadway, Building 19, Suite 110
Fort Wayne, IN 46802

☐ Credit card

Proceed to the next page to complete the credit card payment.

PAYMENT OPTIONS

100% of the premium and ROSTER (name and age) are due upon receipt of this supplemental. This cost is 100% fully earned at inception. Premium finance payments cannot be accepted, unless the premium finance company agrees to 100% fully earned payment.

Submit a completed supplemental and payment via one of the options below.

Applicant business name: _____ Effective date: _____

PAY BY ACH (Bank account): THIS OPTION IS ONLY AVAILABLE FOR PURCHASES MADE 15 DAYS OR MORE PRIOR TO THE EFFECTIVE DATE.

- **E-mail** info@sportsinsurance-kk.com
or

- **Fax** 1-260-459-5105

I (we) authorize K&K Insurance Group to initiate a single electronic debit from the account shown below and have attached a voided copy of the check.

Name on bank account: _____ Bank name: _____

Draft amount: \$ _____ ☐ Checking or ☐ Savings

Bank routing number:* _____ Bank account number:* _____

*See below for an explanation of where to locate these two sets of numbers on your check.

Authorized signature(s) - (Not required if authorization by phone by us.)

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EXPLANATION OF CHECK NUMBERS

1. Bank routing number - This is a nine digit number separated by a bar and a colon I: 123456789 I:
2. Account number - This number may appear as the second, first, or third series of numbers. Please read carefully.
3. Check number - Matches number in the upper right corner of check. NOT REQUIRED FOR ACH.

YOUR NAME
1234 Main Street
Anywhere, OH 00000

DATE _____ 123

PAY TO THE ORDER OF _____ \$ _____

DOLLARS

123456789 123456789 1234

1. ROUTING NUMBER 2. ACCOUNT NUMBER 3. CHECK NUMBER

PAY BY CREDIT CARD:

- **Fax only** 1-260-459-5105

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

Card number: _____

CSC # (card security) code: _____ Expiration date: _____

I authorize K&K Insurance Group, Inc. to charge my payment to my credit card in the amount of \$ _____

Print name (as on card): _____

Cardholder signature: _____

Cardholder phone number: (____) _____

FATCA Notice: Please go to Aon.com/FATCA to obtain appropriate W-9.