Youth Camp and Clinic Supplemental Request Form

For Adding Additional Camp and/or Clinic Session Dates

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: _____

EXPOSURE INFORMATION

Please note:

- You must submit this request form, along with payment, prior to the start of your camp and/or clinic. Coverage cannot be bound without proper payment and a completed and approved supplemental application.
- You must provide the actual or maximum amount of expected campers. TBD numbers can not be accepted.
- Any changes to the reported numbers must be submitted in writing on or before the start of the camp and/or clinic session.
- Cancellations must be submitted in writing on or before the start of the camp and/or clinic session.

1. Do any of your camps include any of the following sports? ❍ Yes ❍ No

If yes, please check those that apply and answer questions a. and b.

❍ Cheerleading	❍ Gymnastics	❍ Roller hockey (quad)
❍ Deck/floor/street hockey	❍ Ice hockey	❍ Soccer/Futsal
❍ Field hockey	❍ Inline hockey	❍ Water hockey
❍ Football	❍ Lacrosse	❍ Wrestling

a. Do you have concussion management protocols/guidelines that are consistently enforced and includes communication (in written or electronic form) of educational materials to participants, parents, and coaches regarding the risks of concussions including but not limited to information on prevention and preparedness to keep athletes safe; understanding concussions and potential consequences of injury; recognizing concussion symptoms and how to respond; and the steps for returning to play after a suspected concussion? ❍ Yes ❍ No

b. If you suspect an athlete has a concussion, do you have an action plan that includes:

- Immediately removing the athlete from play or practice? ❍ Yes ❍ No
- Keeping the athlete out of play or practice until they provide written clearance from a licensed physician? ❍ Yes ❍ No
- Confirming sports liability waivers (informed consent) from parents and/or players are secured? ❍ Yes ❍ No

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

CAMP RATES

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

CLASS 1 SPORTS

Type of Camp Sessions	Option 1 $1,000,000 CGL & $25,000 Med Pay to Part.	Option 2 $2,000,000 CGL & $250,000 Med Pay to Part.	Option 3 $3,000,000 CGL & $250,000 Med Pay to Part.	Option 4 $4,000,000 CGL & $250,000 Med Pay to Part.	Option 5 $5,000,000 CGL & $ 250,000 Med Pay to Part.
Daily (no overnight sessions) • 2 consecutive days or less; OR • Multiple non-consecutive days	$1.45	$1.97	$2.16	$2.27	$2.35
Weekly (no overnight sessions) 3–7 consecutive days	$4.33	$5.99	$6.55	$6.89	$7.13
Overnight/Resident • 1–7 consecutive days NOTE: Adult-accompanied camps are not eligiblefor this option	$5.75	$7.95	$8.69	$9.13	$9.46

CLASS 2 SPORTS

Type of Camp Sessions	Option 1 $ 1,000,000 CGL & $25,000 Med Pay to Part.	Option 2 $2,000,000 CGL & $250,000 Med Pay to Part.	Option 3 $3,000,000 CGL & $250,000 Med Pay to Part.	Option 4 $4,000,000 CGL & $250,000 Med Pay to Part.	Option 5 $5,000,000CGL & $250,000 Med Pay to Part.
Daily (no overnight sessions) • 2 consecutive days or less; OR • Multiple non-consecutive days	$1.60	$2.20	$2.42	$2.55	$2.65
Weekly (no overnight sessions) 3–7 consecutive days	$4.78	$6.66	$7.34	$7.74	$8.04
Overnight/Resident • 1–7 consecutive days NOTE: Adult-accompanied camps are not eligiblefor this option	$6.34	$8.83	$9.72	$10.25	$10.65

Note: Class 2 rates include Limited Neurodegenerative Injury Coverage to Specified Players for sports or athletic activities for those sports with this limitation. 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 for and purchased this coverage at the time of the original binding.

Daily Rate	Weekly Rate	Overnight Resident Rate
$0.15	$0.45	$0.59

CAMP PREMIUM CALCULATIONS

IMPORTANT INFORMATION:

1. Please list each camp session individually. Do not combine a period of camp dates. Should you have more than 3, please provide additional copies of this page.
2. Coverage only applies to those camp sessions specifically reported and approved, before the camp starts.
3. The same limit option must be used for all camps.
4. If multiple sports are in a single camp, the highest sport class applies for that camp.

CAMP/SESSION #1

Name of camp: _____

Type of camp (list ALL the sport (s)/activity(ies): _____

Dates of camp: ____/____/____ to ____/____/____ Hours of operation: _____ A.M. ❍ P.M. ❍ to _____ A.M. ❍ P.M. ❍

Camp days (circle all that apply): Mon ❍ Tues ❍ Wed ❍ Thurs ❍ Fri ❍ Sat ❍ Sun ❍

Camp location(s): _____

# of youth campers/participants (under age 19):_____ # of accompanying parent/guardian participants: _____

Does your current policy include Sexual Misconduct Liability coverage? ❍ Yes ❍ No

If YES, make sure to include rating below. If NO, do not include sexual misconduct rate.

Coverage Option	Daily or Weekly Rate	+	Sexual Misconduct Rate (only if yes is checked above)	=	Total Rate	x	# of Days or Weeks	x	# of Campers (add youth + accompanying parent/guardian)	=	Premium
	$	+	$	=	$	x		x		=	$

CAMP/SESSION #2

Name of camp: _____

Type of camp (list ALL the sport (s)/activity(ies): _____

Dates of camp: ____/____/____ to ____/____/____ Hours of operation: _____ A.M. ❍ P.M. ❍ to _____ A.M. ❍ P.M. ❍

Camp days (circle all that apply): Mon ❍ Tues ❍ Wed ❍ Thurs ❍ Fri ❍ Sat ❍ Sun ❍

Camp location(s): _____

# of youth campers/participants (under age 19):_____ # of accompanying parent/guardian participants: _____

Does your current policy include Sexual Misconduct Liability coverage? ❍ Yes ❍ No

If YES, make sure to include rating below. If NO, do not include sexual misconduct rate.

Coverage Option	Daily or Weekly Rate	+	Sexual Misconduct Rate (only if yes is checked above)	=	Total Rate	x	# of Days or Weeks	x	# of Campers (add youth + accompanying parent/guardian)	=	Premium
	$	+	$	=	$	x		x		=	$

CAMP/SESSION #3

Name of camp: _____

Type of camp (list ALL the sport (s)/activity(ies): _____

Dates of camp: ____/____/____ to ____/____/____ Hours of operation: _____ A.M. ❍ P.M. ❍ to _____ A.M. ❍ P.M. ❍

Camp days (circle all that apply): Mon ❍ Tues ❍ Wed ❍ Thurs ❍ Fri ❍ Sat ❍ Sun ❍

Camp location(s): _____

# of youth campers/participants (under age 19):_____ # of accompanying parent/guardian participants: _____

Does your current policy include Sexual Misconduct Liability coverage? ❍ Yes ❍ No

If YES, make sure to include rating below. If NO, do not include sexual misconduct rate.

Coverage Option	Daily or Weekly Rate	+	Sexual Misconduct Rate (only if yes is checked above)	=	Total Rate	x	# of Days or Weeks	x	# of Campers (add youth + accompanying parent/guardian)	=	Premium
	$	+	$	=	$	x		x		=	$

CERTIFICATE REQUESTS

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.

CERTIFICATE REQUEST #1

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

1. Camp #:_____

2. When is this certificate needed? : _____/_____/_____

3. 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.

4. Certificate holder/additional insured name: _____

_____

Mailing address: _____

City: _____ State: _____ Zip: _____

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

If yes, check all that apply: ❍ CG2026 ❍ Primary ❍ 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.

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

CERTIFICATE REQUEST #2

1. Camp #:_____

2. When is this certificate needed? : _____/_____/_____

3. 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.

4. Certificate holder/additional insured name: _____

_____

Mailing address: _____

City: _____ State: _____ Zip: _____

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

If yes, check all that apply: ❍ CG2026 ❍ Primary ❍ 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.

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.

FINAL PAYMENT CALCULATION AND PAYMENT OPTIONS

Step 1: Applicant business name from page 1:_____

Step 2: Enter additional camp premiums:

Liability premium (total premium from all additional camps) from page 3. $_____(a)

Step 3: Calculate surplus lines/stamping/transaction fees – this is based on the Named Insured's state from page 1.

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: COST TOTAL (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
Camp RPG Program
P.O. Box 2338
Fort Wayne, IN 46801-2338

Overnight: K&K Insurance
Camp RPG Program
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

Submit 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@campinsurance-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.

_____ Date: _____

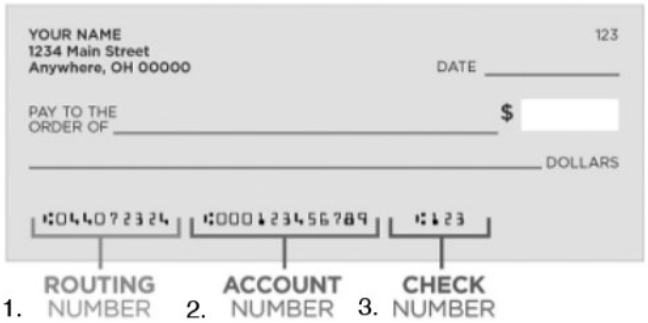
Authorized signature(s) - (Not required if authorization by phone by K&K.)

_____ Date: _____

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

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.



❍ **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.