



MEMBER 

# Membership Application

Company Name \_\_\_\_\_

Contact Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Zip \_\_\_\_\_

E Mail \_\_\_\_\_ Website \_\_\_\_\_

Type of Business \_\_\_\_\_ Years in Business \_\_\_\_\_ Years of Experience \_\_\_\_\_

**Key Contact People**

President \_\_\_\_\_  Other \_\_\_\_\_

Accounting Manager \_\_\_\_\_

- |   |                                |  |
|---|--------------------------------|--|
| Non Profit Corp. <input type="checkbox"/> | PLEASE CHECK ORGANIZATION TYPE | <input type="checkbox"/> Sub Chapter S |
| Corporation <input type="checkbox"/>      |                                | <input type="checkbox"/> Partnership   |
| LLC <input type="checkbox"/>              |                                | <input type="checkbox"/> Joint Venture |
| <input type="checkbox"/> Other _____      |                                |  |

Date \_\_\_\_\_

Applicant Signature \_\_\_\_\_



**American Amateur Sports Association**

**THANK YOU FOR YOUR SUPPORT!**

Attention applicant: Please complete at locations wherever you see: ✓

<h1 style="margin: 0;">Participant Accident Insurance</h1> <p style="margin: 0;"><i>Enrollment Request Form</i></p>	<h2 style="margin: 0;">SPORTS</h2>
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- ✓ A. Name of Policyholder \_\_\_\_\_
- ✓ B. Address \_\_\_\_\_
- ✓ C. Requested Start Date of Coverage \_\_\_\_\_
- D. Requested End Date of Coverage \_\_\_\_\_
- E. Policy to Cover  Participants only  
(please check one box)  
 Participants and Coaches, Trainers, Team Managers

Accidental Death, Dismemberment Dental, and Paralysis Maximum <small>(offered on all plans)</small>	Accident Medical Expense Maximum	Deductible Amount	Benefit Plan Selection:
\$15,000 Accidental Death Benefit	<input type="checkbox"/> \$250,000 <input type="checkbox"/> \$10,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$50	<input checked="" type="checkbox"/> Full Excess (not available in NH, OR, PA, or TX)
\$50,000 Accidental Dismemberment (\$15,000 in CT, MN, NH, NJ, PA, SC, TN, TX)	<input type="checkbox"/> \$100,000 <input type="checkbox"/> \$5,000	<input checked="" type="checkbox"/> \$250 <input type="checkbox"/> \$25	<input type="checkbox"/> Primary/Excess
\$50,000 Total Paralysis <small>(Not Available: CT, MN, NH, NJ, PA, SC, TN, TX)</small>	<input checked="" type="checkbox"/> \$50,000	<input type="checkbox"/> \$100 <input type="checkbox"/> \$0	<small>(MUST SELECT A PRIMARY/EXCESS \$ AMOUNT)</small> <input type="checkbox"/> \$100 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500
\$500 Dental	<input type="checkbox"/> \$25,000		<input type="checkbox"/> Primary

G. Policy Premium Computation

Sport	Age Range of Participants	Number of Parts.	O R	Number of Teams	Base Rate	Total Base Premium
<b>Paintball</b>				X	=	
				X	=	
				X	=	
				X	=	
Total						

**PREMIUM MODIFICATION FACTORS**  
(multiply premium modification factors; if applicable against the Total Base Premium)

Total Base Premium	Medical Maximum Factor	Primary Excess Factor	Deductible Factor	League Discount Factor	Grand Total Premium
X		X			X

H. I understand and agree that this is only an enrollment request form and is not an agreement to bind coverage. If quote is agreed upon by both the Agent/Broker and the Insurance Company and payment of the required premium is remitted, coverage will begin on the date premium is remitted or on the date indicated in Section C, whichever is later.

- ✓ Signature of Applicant \_\_\_\_\_ Date Signed \_\_\_\_\_
- Signature of Agent/Broker \_\_\_\_\_ Date Signed \_\_\_\_\_
- Agent/Broker Name, Address \_\_\_\_\_
- Phone \_\_\_\_\_