

**NOCAD**  
**Certificate of Insurance Request Form**  
**All-Star Games                  Summer Camps                  Clinics**

Name of Member State Association \_\_\_\_\_

Name of Camp or All-Star Event \_\_\_\_\_

Dates of Coverage: Begin \_\_\_\_\_ End \_\_\_\_\_

Location (Venue) of Camp/All-Star Event: \_\_\_\_\_  
(Certificate Holder/Venue requesting certificate and/or proof of insurance coverage.)

Venue Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Venue Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Fax \_\_\_\_\_

Does the Certificate Holder require additional insured status? Yes or No

If yes, additional fee will apply and participant accident coverage is required.

If yes, please specify "additional insured" wording as it should appear: \_\_\_\_\_

Other Additional Insured as requested below: (Provide name as it should appear and address)

1. \_\_\_\_\_

2. \_\_\_\_\_

\*\*\*\*\*

By submitting this form I am certifying that I am a current member in good standing with my state association.

Your name \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Fax \_\_\_\_\_

Your address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Forward to: Loomis & LaPann Inc. by FAX 518-792-3426 or email [sports@loomislapann.com](mailto:sports@loomislapann.com)  
Questions: Toll Free 800-566-6479 Karen Boller, Kevin Joyce or Greg Joly

**NOCAD**  
**Participant / Accident Request Form**  
**All-Star Games      Summer Camps      Clinics**

Name of Member State Association \_\_\_\_\_

Event Name \_\_\_\_\_

Event Location \_\_\_\_\_

Event Address \_\_\_\_\_

Effective date of coverage \_\_\_\_\_ Termination date of coverage \_\_\_\_\_

# of Participants \_\_\_\_\_ # of Coaches/Volunteers \_\_\_\_\_ # of Days \_\_\_\_\_ Sport \_\_\_\_\_

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# of Participants \_\_\_\_\_ # of Coaches/Volunteers \_\_\_\_\_ # of Days \_\_\_\_\_ Sport \_\_\_\_\_

**Please select one option from the Participant Accident Medical Plans:**

Option 1: \$25,000 Maximum Medical, Accidental Death \$5,000, Deductible \$250

Option 2: \$300,000 Max. Medical, Accidental Death \$5,000, Deductible \$25,000

Prior Insurance History: Did you have Prior Coverage?       Yes       No

_____ Year	_____ Carrier	_____ Premium Paid	_____ Losses Paid
_____ Year	_____ Carrier	_____ Premium Paid	_____ Losses Paid
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The above information is correct to the best of my knowledge. I understand the company must approve my request before coverage is effective. Coverage is not bound until payment is received. By submitting this form I am certifying that I am a current member in good standing with my state association.

Signature \_\_\_\_\_

Email \_\_\_\_\_

Name \_\_\_\_\_

Phone \_\_\_\_\_

Date \_\_\_\_\_

Fax \_\_\_\_\_

For quotation: Loomis & LaPann, Inc. by FAX 518-792-3426 or email [sports@loomislapann.com](mailto:sports@loomislapann.com)  
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Rating completed by Loomis & LaPann, Inc.

# of Participants \_\_\_\_\_ x days \_\_\_\_\_ x rate \_\_\_\_\_ = Premium \_\_\_\_\_

Minimum premium \$225.00 – Administration Fee \$25.00