



# ADULT TEAM SPORTS ACCIDENT INSURANCE

## ENROLLMENT FORM FOR ACCIDENTAL DEATH & ACCIDENT MEDICAL BENEFITS

Cossio Insurance Agency • 864-688-0121 • Fax: 864-688-0138 • PO Box 188 Simpsonville SC 29681

### Section 1: PROPOSED POLICYHOLDER

Full Legal Name of Proposed Policyholder:		
Birth Date:	Phone Number:	FEIN/SS#:
Address:		
City:	State:	Zip:
Specified Activity:		
Requested Effective Date:	Termination Date:	
Policy will become effective on the Requested Effective Date if (a) all required information is provided and (b) the Company has received the initial premium on or before that date.		

### Section 2: PLAN OF INSURANCE & PREMIUM CALCULATION

Plan of Benefits		<i>Policy to cover All Players, Coaches, Managers, and Volunteers of the Policyholder</i>			
Accidental Death & Dismemberment Principle Sum: \$					
Maximum Medical Expense Benefit: \$			Deductible amount: \$		
Premium Calculation <i>Minimum Premium is \$250.00</i>					
Classification of Insured Persons or Group	Number Eligible		Rate Per Player		Total
		x		=	
		x		=	
		x		=	
		x		=	
		x		=	
Total Premium: \$		Discounts (if applicable): \$		Total Premium Due: \$	

### Section 2: ACKNOWLEDGEMENTS & SIGNATURES

**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.

Date:	Licensed Agent Signature:	Agent Phone:
Signed for the Proposed Policyholder:		Licensed Agent Number:
Title:	Agent Address:	

Save the application & send us an email to [apps@cossioinsurance.com](mailto:apps@cossioinsurance.com) and attach the PDF Application.

SAVE APPLICATION