



GYMNASTICS APPLICATION

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

DIRECTIONS:

1. Complete the application (all pages) in full by filling in the blue fields.
2. Please fill in all the fields with the correct information.
3. Email the application to apps@cossioinsurance.com or Fax to 864-688-0138

Section 1: GENERAL INFORMATION

How did you hear about us?

Insured Name/Business Name/DBA:

Club Name:

Mailing Address:

City:

State:

Zip:

Contact Name:

DOB:

FEIN/SS#:

Phone Number:

Fax:

E-mail:

Website:

My club has the following on the club premises: ☐ Swimming Pool(s) Number of Pools
☐ Soft Play Area(s) Annual Receipts\$ ☐ Inflatables Call CIA

Are you teaching any circus skills? (trapeze, high wire, etc.) ☐ Yes ☐ No

Site address(es) if different from above. If additional space is needed, please use a separate sheet with this application.

Location 1

City:

State:

Zip:

Location 2

City:

State:

Zip:

Location 3

City:

State:

Zip:

Please list any persons, landlords, or organizations requiring you to list them as an "additional insured" on your policy (usually this is done through a lease/rental agreement or contract).

Name:

Relationship: ☐ Landlord ☐ Sponsor

Address:

Other:

Name:

Relationship: ☐ Landlord ☐ Sponsor

Address:

Other:

Name:

Relationship: ☐ Landlord ☐ Sponsor

Address:

Other:

Section 2: PREMIUM CALCULATION

PART 1 General Liability and Medical Payments to Participants

Using the rates listed below, complete the following calculation. Estimate the greatest number of participants in each category that will be enrolled in your programs at your busiest time of the year. If you have 500 or more participants, please contact our office. Minimum premium of \$870 will apply if the subtotal line (A) does not exceed \$870.

Number of Participants & Staff	x	Rate	= Annual Premium
Ages 7 and Over		\$25.84	\$
Ages 5 & 6		\$20.70	\$
Ages 4 & Under		\$11.12	\$
Subtotal			(A) \$

PART 2 Optional Coverages

Abuse & Molestation: Separate questionnaire must be completed and approved by a company underwriter to purchase this coverage.

Number of Locations	x	\$500	=	(a) \$
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Subsidiary Activities

The activities below are not covered under your basic coverage unless you have reported them on the enrollment form and paid the appropriate premium. If purchased, coverage is extended under your basic coverage to the activities selected.

Report the number of participants in each activity.

Yoga/Exercise/Aerobics #	Music Lessons #
Basketball/SoccerNolleyball #	Swimming #
Arts & Craft Classes #	Meeting/Seminars #
Trial or Open Gymnastics #	Martial Arts #
Dance Classes #	Climbing Walls #

Maximum fall height ft.	Do you require a safety harness? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Martial Arts participants:.	x	\$19.42	=	(b) \$
All other activities participants:	x	\$13.40	=	(c) \$

Birthday/Social Parties:

Number of Parties annually:	x	\$16.78	=	(d) \$
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Swimming Pools / Softplay Areas (Liability coverage only):

Number of Swimming Pools:	x	\$588.00	=	(e) \$
Annual Softplay Area Receipts:	x	\$481.70	=	(f) \$
Subtotal: Add lines a .b .c .d .e .f				(B) \$

Section 2: PREMIUM CALCULATION (Continued)

PART 3 Equipment & Contents Coverage (optional)

Subject to a \$100 minimum premium. \$1 ,000 Deductible per loss. Coverage unavailable in New Jersey

My total value of equipment is \$4,000 or less (a) \$100.00

If equipment is valued over \$4.000 please calculate premium here:

Amount of replacement cost of equipment \$ x rate .025 = (b)

Subtotal: Amount of lines a or b (C)

Premium Summary

Total General Liability Premium (\$870.00 minimum) (A) \$

Total Optional Coverages Premium (B) \$

Equipment and Contents Coverage Premium (\$100 minimum) (C) \$

Brokerage (D) \$400

Total Insurance Premium (Total of A, B, C and D) (E) \$

Section 3: PAYMENT

Select Payment /Installment Plan (check one)

☐ 100% PLAN (check or credit card)

Coverage can be bound upon receipt of the following:
Completed & signed enrollment form, 100% premium payment.

Make check payable to Cossio Insurance Agency or complete the credit/debit card information.

☐ 30/70 PLAN (check or credit card)

Coverage can be bound upon receipt of the following:
Completed & signed enrollment form, 30% of your total premium. (30 % of Line D)

Make check for down payment payable to Cossio Insurance Agency or complete the credit/debit card information. You will be invoiced for the balance of the premium which will be due within 30 days of your effective date.

☐ 25 + 3 PLAN (credit card only) Only available for premiums of \$1,500 or more.

Coverage can be bound upon receipt of the following:
Completed & signed enrollment form, 25% of your total premium (25% of Line D) paid by your credit card

Complete the credit/debit card information. Your 75% premium balance will be charged to your credit/debit card in three (3) equal monthly payments

Section 4: MAKING YOUR PAYMENT

☐ Check Please make check payable to Cossio Insurance Agency. Enclosed is check #
In the amount of \$

Please Continue on to the next page for credit card options.

Section 4: MAKING YOUR PAYMENT (Continued)

☐ Credit Card If you are making your payment by credit/debit card, please complete the following:
I authorize CIA Insurance to charge my card as follows:

☐ 100% PLAN Amount from Line D \$

☐ 30/70 PLAN 30% of Line D \$

☐ 25+3 PLAN 25% of Line D \$

The balance premium (75% of Line D) will be charged to your Credit card number in three (3) equal monthly installments, Starting one (1) month after your effective date.

☐ Visa ☐ Mastercard

Card Number	Print Name (as on card)
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Cardholder Signature	Expiration Date
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Note: Any premium bearing endorsements to the policy will be invoiced separately and are payable in full

NOTE: RETAIN A COPY OF THIS ENROLLMENT FORM FOR YOUR RECORDS.

I am aware that the insurance company expects my enrollment figures to be accurate, and based upon those of the peak month of registrations (busiest month) of the year. Should my enrollment, at any time, exceed the numbers specified on the application form, I will make arrangements to pay the difference at the standard rates shown on the enrollment form by submitting the amendment form which will accompany the policy.

I further understand that the school's premium is based upon a fair and equal sharing of the total annual amount by each student and staff member. For this reason, should the school need to increase the total number of participants at a later date, prorating of premium is not available, and premium rates on the application form apply. I agree that registration records at my school are available to audit by the insurers at any time.

☐ I am not currently insured with CIA Please start coverage on date received by CIA or later date:

☐ I am currently insured with CIA Please start coverage on:

I understand that the insurance company, in determining whether to provide insurance coverage, will rely on the information contained in this form and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

I further acknowledge that I have reviewed all information provided with this enrollment form and understand the exclusions that apply, as well as the activities and operations for which coverage is not provided.

Signature of School Representative:

Print Name of School Representative:

Date Signed:



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Section 5: FOR INSURANCE AGENTS ONLY

Agency Name:		
Agency Mailing Address:		
City:	State:	Zip:
Agent/ContactName:		
Agency Telephone :		Agency Fax:
Agent/Contact Email Address:		

POLICY RECOMMENDATIONS (Please check any you are interested in)

General Liability <input type="checkbox"/>	Accident Medical <input type="checkbox"/>	Earthquake <input type="checkbox"/>
Inland Marine <input type="checkbox"/>	Workers Compensation <input type="checkbox"/>	Commercial Auto <input type="checkbox"/>
EPLI <input type="checkbox"/>	Flood <input type="checkbox"/>	Hired & Non-Owned Auto <input type="checkbox"/>
Umbrella <input type="checkbox"/>	Abuse / Molestation <input type="checkbox"/>	
Cyber Liability <input type="checkbox"/>		

PLEASE CONTINUE ON TO THE NEXT PAGE TO READ & SIGN FRAUD STATMENT



FRAUD NOTICE

GENERAL STATEMENT: Any person who knowingly and with intent to defraud any insurance company or another 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 is a crime and subjects the person to criminal and [NY: substantial] civil penalties. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN, and VA, insurance benefits may also be denied)

APPLICABLE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN THE DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORDIA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

APPLICABLE IN HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT: Any person who knowingly and with intent to defraud any insurance company or another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

APPLICABLE IN MINNESOTA: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I understand that the insurance company, in determining in whether to provide insurance coverage, will rely on the information contained in this form and all other information submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

Insured Signature:

Date:

SAVE APPLICATION