

E.R.B INSURANCE GROUP, LLC  
Camps and Clinics Quote Form

Named Insured \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Contact or Coach \_\_\_\_\_

Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Sport(s) or Event \_\_\_\_\_

Ages of Participants \_\_\_\_\_

For Football: Tackle \_\_\_\_\_ Non-contact \_\_\_\_\_ QB \_\_\_\_\_ Kicking/Punting \_\_\_\_\_ (check all that apply)  
(if Applicable)

Are you conducting: \_\_\_\_\_ Day Camps \_\_\_\_\_ Overnight Camps \_\_\_\_\_ Clinics \_\_\_\_\_ Tournament \_\_\_\_\_

Effective Dates of Coverage requested: \_\_\_\_\_ thru \_\_\_\_\_ annual policies are subject to

audit. Do you have parents sign waivers or permission form? Yes \_\_\_\_\_ No \_\_\_\_\_ (please include a copy with your signed application) Do you have a risk management plan in place? Yes \_\_\_\_\_ No \_\_\_\_\_ please send copy of camp brochure. Do you remove player in case of concussion? Yes \_\_\_\_\_ No \_\_\_\_\_ Will the player only return from play with doctor's clearance? Yes \_\_\_\_\_ No \_\_\_\_\_

Rate Section:

- General Liability

\$1,000,000.00 per occurrence

\$3,000,000.00 or \$5,000,000 Aggregate

\$0.00 deductible

\$1,000,000 Hired/non-owned auto(optional)

\$1,000,000 Abuse Molestation (optional)

Excess Accident Medical

\$10,000 or 25,000 per accident

\$5000.00 AD & D

\$100.00 Deductible

**PLEASE COMPLETE THIS SECTION:**

Estimated # Of Day Campers: \_\_\_\_\_ X # of Days: \_\_\_\_\_

\* Exact Dates of Camp: \_\_\_\_\_

Estimated # Of Overnight Campers: \_\_\_\_\_ X # of Days: \_\_\_\_\_

\* Exact Dates of Camp: \_\_\_\_\_

# Of Coaches and Staff: \_\_\_\_\_

Optional Coverage: Abuse Molestation- \$175.00 (will be added to final quote if desired)

Add to quote: \_\_\_\_\_ YES \_\_\_\_\_ NO

Above information is for Quote purposes only. An enrollment form will be sent if quote is accepted.

Total Premium will be due upon approval of quote. Enrollment application and payment must be received in the office 10 days prior to the effective date requested. (Coverage will not be bound without payment)

Any person who, with intent to defraud or knowing that he/she is facilitating against an insurer, submits application or files claims containing a false or deceptive statement is guilty of insurance fraud.

Authorized Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

Complete the above. Please fill in all blanks requested to avoid delays.

**708 ALLEN CT. CROWLEY, TEXAS 76036**

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