



International Travel Athletic Accident & Sickness Insurance Request for Proposal



Coverage terms, conditions, limitations and exclusions may vary and may not be available in all states.

Requested Effective Date: _____	When would you like to receive your quote? _____
Your Name: _____	Email Address: _____

Prospect Information		
College/University Name: _____		
Physical Address: _____		
City: _____	State: _____	Zip Code: _____
Does your school have an insurance agent or broker? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, would you like us to contact them? <input type="checkbox"/> Yes (Please complete section below) <input type="checkbox"/> No		
Agent/Broker Name: _____		Company: _____
Agent/Broker Contact Information: _____		

Description of Covered Trip and Travel Party Members				
Does your school have an Intercollegiate Sports (ICS) policy that covers injuries occurring outside of the U.S., Canada, and Mexico? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Sport/Activity: _____			Number of days of athletic competition or practice: _____	
Please enter the number of Travel Party Members below.				
Student-Athletes	Coaches	Trainers	Student Managers	Guests
Number of Travel Party Members Under Age 18: _____ Age 18 or Older: _____ Maximum Age: _____				
Destination(s)		Length of Stay		
How will your Travel Party Members travel to your destination(s)? Please check all that apply.				
<input type="checkbox"/> All Travel Party Members on one commercial flight <input type="checkbox"/> Multiple commercial flights <input type="checkbox"/> Chartered Aircraft <input type="checkbox"/> Owned Aircraft <input type="checkbox"/> Other _____				

Terms of Acknowledgement

Terms of Acknowledgement and Signature: This Request for Proposal (RFP) is not a contract of insurance. No coverage is bound or afforded by this RFP. A proposal will be based on information included in this RFP. The undersigned hereby certifies that this information accurately represents the facts and that no requested information has been misrepresented, misstated, omitted, or altered. In the event that the undersigned becomes aware of facts that would have a material effect on the proposed coverage, any such facts or information will be immediately reported to carrier. I understand that if information material to the underwriting of this coverage changes, the carrier reserves the right to pursue, without limitation, an adjustment of premiums or coverage, in accordance with such correct facts or information and any other remedies available through operation of law or at equity.

Electronic Signature:

Please type your First and Last Name.

Title: _____

Date: _____

I understand that checking this box constitutes a legal signature confirming that I understand and agree to the above Terms of Acknowledgement. **Please do not forget to type your name in the E-Signature section.**

Please email completed form to jgiunta@agadm.com

Insurance provided is underwritten by Berkley Life and Health Insurance Company and/or StarNet Insurance Company, both member companies of W. R. Berkley Corporation and both rated A+ (Superior) by A.M. Best. For complete details, please contact **Joe Giunta, A-G Specialty Insurance, LLC** at jgiunta@agadm.com.