



8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-585-2853 • Fax 877-585-2854
quotes@primeis.com

MARTIAL ARTS

General Information

Proposed Effective Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Applicant's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ County: \_\_\_\_\_

Business Telephone Number: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Physical Address of Business (if different): \_\_\_\_\_

Population within 50 miles: \_\_\_\_\_

Other Locations Used:

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list any other names the business is or has been known by: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Producer No.: \_\_\_\_\_ Producer's Name: \_\_\_\_\_

Producer's E-mail: \_\_\_\_\_

Detailed description of business activities (specifically, and by location): \_\_\_\_\_

Is this a new business? [ ] Yes [ ] No If no, how many years have you been in business? \_\_\_\_\_

Applicant is: [ ] Individual [ ] Corporation [ ] Partnership [ ] Joint Venture

[ ] Other (please describe): \_\_\_\_\_

Annual Payroll: \$ \_\_\_\_\_

Total Number of Employees: \_\_\_\_\_ Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? [ ] Yes [ ] No

If yes, please tell us:

Employee Name: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Business Telephone No.: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_ Years with Company: \_\_\_\_\_

Employee's Responsibilities: \_\_\_\_\_

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? \_\_\_\_\_

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

Has the Applicant or any predecessor or related person or entity ever had a claim?  Yes  No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?  Yes  No

If the standard markets are declining placement, please explain why: \_\_\_\_\_  
 \_\_\_\_\_

**2. Desired Insurance**

**Limit of Liability - Professional Liability Coverage:**

Per Act/Aggregate		OR	Per Person/Per Act/Aggregate	
<input type="checkbox"/>	\$50,000/\$100,000	<input type="checkbox"/>	\$25,000/\$50,000/\$100,000	
<input type="checkbox"/>	\$150,000/\$300,000	<input type="checkbox"/>	\$75,000/\$150,000/\$300,000	
<input type="checkbox"/>	\$250,000/\$1,000,000	<input type="checkbox"/>	\$100,000/\$250,000/\$1,000,000	
<input type="checkbox"/>	\$500,000/\$1,000,000	<input type="checkbox"/>	\$250,000/\$500,000/\$1,000,000	
<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	Other: _____	

**Self-Insured Retention (SIR):**  \$1,000 (Minimum)  \$1,500  \$2,500  \$5,000  \$10,000

**3. Business Activities**

1. Person providing accounting and tax services:

a. Name: \_\_\_\_\_

b. Address: \_\_\_\_\_

2. List all activities taking place, and the annual number of students:

ACTIVITY	NUMBER OF STUDENTS
<input type="checkbox"/> Martial Arts	
<input type="checkbox"/> Weight Training	
<input type="checkbox"/> Aerobics	
<input type="checkbox"/> Other: _____	

3. Please include any information that adequately describes your premises, such as photos, brochures, and a diagram of the premises.

4. With regard to the premises where activities take place, Applicant is:

Owner       Tenant --provide name & address of owner: \_\_\_\_\_  
\_\_\_\_\_

Other (explain): \_\_\_\_\_

5. Is the studio practice area secured from use by any other persons than instructors or trainees under supervision during regular operating hours?  Yes  No

6. Number of square feet: \_\_\_\_\_

7. What is the name and style of martial art taught at your facility? \_\_\_\_\_

8. Which type of contact is allowed or taught?  Full contact  Light contact  Touch contact

No Contact (describe): \_\_\_\_\_

9. Do you do weapons training?  Yes  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

10. Do you hold tournaments or competitions?  Yes  No

If yes, are they:  Students only  Club members only  Open competition

Other \_\_\_\_\_

**NOTE:** Competitions held at other facilities with your regular students are covered. Competitions held at your facility can be included if you obtain a certificate of Additional Insured from the visiting program naming you as Additional Insured. If that is not obtainable, each competition can be scheduled and added for a fee.

11. Do you conduct off-premises activities?  Yes  No

If yes, please indicate:  Competitions/tournaments  Testing  Demonstrations/Instruction

Other: \_\_\_\_\_

12. What are your requirements or belt levels for free sparring? \_\_\_\_\_  
\_\_\_\_\_

13. How much training is required prior to free sparring?  2-4 months  4-6 months  6 months or more

14. Describe all protective safety equipment worn by students while sparring: \_\_\_\_\_  
\_\_\_\_\_

15. What is the average number of students who undergo advancement testing each month? \_\_\_\_\_

16. How many students undergo advancement testing annually: \_\_\_\_\_

17. Are all students warned as they progress through the various skills, of the inherent risks involved in participating and of the rules of participation?  Yes  No

18. Do you obtain medical information on participants prior to participation?  Yes  No

19. Do you have a medical emergency plan and procedures?  Yes  No

20. Are your instructors certified by a nationally accredited and recognized martial arts program?

If yes, please tell us:  Yes  No

a. Name of Program: \_\_\_\_\_

b. Phone: (\_\_\_\_) \_\_\_\_\_

c. Address: \_\_\_\_\_

d. What are instructor requirements for certification? \_\_\_\_\_  
\_\_\_\_\_

21. Is continuing education and training required for instructors?  Yes  No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

22. What are the objectives and goals of your school? \_\_\_\_\_

23. Minimum age of instructors, supervisors, instructors, managers, or employees: \_\_\_\_\_

24. Number of students annually: Beginners: \_\_\_\_\_ Advanced: \_\_\_\_\_

25. How do you charge your students?  Per lesson  Monthly  Contracts  Other: \_\_\_\_\_

26. Total maximum enrollment last year: \_\_\_\_\_

27. What are the most people that you could have participating in one day? \_\_\_\_\_

28. Are students, regardless of talent, required to master each step in a skills progression before advancing to more difficult skills?  Yes  No

29. Do you keep Performance Chart records or skill sheet equivalent on each trainee?  Yes  No

30. Do you obtain a liability release form and a consent for medical treatment form from each trainee, or trainee's parents or legal guardian?  Yes  No

If yes, please attach a copy.

31. What is your student-to-instructor ratio? \_\_\_\_\_

32. Do guests sign a release form?  Yes  No

If yes, please attach a copy.

33. Do you control and own all businesses operating on your premises?  Yes  No

34. Have you obtained certificates of insurance from all Independent Contractors or concessions?

If yes, please enclose copies.  Yes  No

35. Provide the total gross receipts and breakdown for all activities, operations and services provided annually. Include gross sales, commissions, fees, or other income:

	GROSS RECEIPTS	# PARTICIPANTS ANNUALLY
Tuitions / memberships / fees	\$	\$
Advancement	\$	\$
Competition (home)	\$	\$
Competition (away)	\$	\$
Open Workouts	\$	\$
Clinics	\$	\$
Merchandising (retail)	\$	\$
Other (describe): _____	\$	\$
<b>Total:</b>	<b>\$</b>	

36. List the products that you sell: \_\_\_\_\_  
 \_\_\_\_\_

37. Do you manufacture and/or sell any products under own label?  Yes  No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

38. Enclose narratives and/or current resumes of experience and training for all instructors and facility owners.

39. Checklist of items to include with this application:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Brochure   | <input type="checkbox"/> Advertising materials                     | <input type="checkbox"/> Liability waiver (if used) |
| <input type="checkbox"/> Operating plan, procedural manual                                  | <input type="checkbox"/> Staff manual                              | <input type="checkbox"/> Emergency plan             |
| <input type="checkbox"/> Managers resume  | <input type="checkbox"/> Staff list, including ages and experience |   |
| <input type="checkbox"/> Certificates of insurance for visiting program to your competition |  |   |

**REPRESENTATIONS AND WARRANTIES**

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

Applicant:

Agent/Broker:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name