



# Martial Arts Schools & Programs Hosted Tournament Supplemental Request Form

Hosted tournaments are those you organize and operate that include participants who are not active members of your organization or school. Hosted tournaments must be 7 days or less in duration.

Please retain a copy of this form for your records.

**GENERAL INFORMATION**

Named insured (as it appears on your certificate of insurance): \_\_\_\_\_

Policy number (as it appears on your certificate of insurance): \_\_\_\_\_

Mailing address: \_\_\_\_\_

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

Contact name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_ Website: \_\_\_\_\_

**EXPOSURE INFORMATION**

- Note:
- You must submit this request form prior to the effective date needed
  - Medical payments for participants coverage is not available with this coverage
  - Hosted tournament premiums are 100% fully earned and non-refundable once the tournament begins
  - Competitions/Events/Tournaments with any of the following styles or similar styles of martial arts are not eligible for this coverage: Dim mak, Haganah, Kali/escrima, Mixed martial arts, Sayoc kali, Thai boxing, Muay thai, Ultimate/extreme/cage fighting

**If you have over 500 non-rostered participants in your hosted tournament, please contact us.**

Premium is determined by applying the appropriate rate for the coverage option selected to your non-rostered participant count. Choose the same limit option selected for your school or organization. For multiple hosted tournaments, complete separate requests with the information provided below for each tournament.

### Tournament Information

Event name: \_\_\_\_\_

Event dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ Event hours: \_\_\_\_ A.M./P.M. to \_\_\_\_ A.M./P.M.

Location: \_\_\_\_\_

Options	# of Non-rostered Participants per Tournament		
	1-50 participants	51-100 participants	101-500 participants
Option 1 \$1,000,000 CGL Limit	<input type="radio"/> \$ 185.37	<input type="radio"/> \$ 368.42	<input type="radio"/> \$ 553.79
Option 2 \$2,000,000 CGL Limit	<input type="radio"/> \$ 278.06	<input type="radio"/> \$ 552.63	<input type="radio"/> \$ 830.69
Option 3 \$3,000,000 CGL Limit	<input type="radio"/> \$ 324.40	<input type="radio"/> \$ 644.74	<input type="radio"/> \$ 969.13
Option 4 \$4,000,000 CGL Limit	<input type="radio"/> \$ 352.20	<input type="radio"/> \$ 700.00	<input type="radio"/> \$1,052.20
Option 5 \$5,000,000 CGL Limit	<input type="radio"/> \$ 372.59	<input type="radio"/> \$ 740.52	<input type="radio"/> \$1,113.12

**Ascension Benefits & Insurance Solutions • P.O. Box 25936 • Overland Park, KS 66225 • 1-800-955-1991**

**E-mail = [programs@ascensionins.com](mailto:programs@ascensionins.com) • Fax 1-913-327-0201 • [www.ascensionins.com/programs](http://www.ascensionins.com/programs)**

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CERTIFICATE REQUESTS

Complete this section to request a certificate. Provide separate requests for each additional certificate needed.

Date needed by: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Check the type of certificate you are requesting:  Additional insured  Evidence of coverage

Certificate holder information:

Entity name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

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

Relationship to named insured:

Owner/lessor of premises  Sponsor  Co-promoter  Other: \_\_\_\_\_

Other than being named on the certificate as an additional insured or certificate holder, does the person or organization require any special wording or endorsements?  Yes  No

If yes, check all that apply (**Check your request carefully before submitting. The most common delay in certificate processing is caused by providing a partial or incorrect name and/or instructions.**)

Form CG2026  Primary endorsement  Waiver of subrogation

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

If applicable: RE: Date(s) of event/activity: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Hours of the event/activity: \_\_\_\_ A.M. / P.M. to \_\_\_\_ A.M. / P.M.

Type of event/activity: \_\_\_\_\_

Name of event/activity: \_\_\_\_\_

Location of event/activity: \_\_\_\_\_

MAILING INSTRUCTIONS

Submit completed supplemental form, with payment, to us.

- E-mail programs@ascensionins.com
- Fax 1-913-327-0201
- Mail Ascension Benefits and Insurance Solutions  
P.O. Box 25936  
Overland Park, KS 66225

FOR OFFICE USE ONLY

Rec: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Policy #: \_\_\_\_\_ Cert #: \_\_\_\_\_ Insured #: \_\_\_\_\_

Opt: \_\_\_\_\_ Premium: \$ \_\_\_\_\_ Eff/Exp: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Comments: \_\_\_\_\_

Opt Form: 2026 2011 2404 8016 8018 876 Delivery: M F E Delivery Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PAYMENT INFORMATION

**Check:** Please make check payable to Ascension Benefits & Insurance Solutions.

Enclosed is check # \_\_\_\_\_ for \$ \_\_\_\_\_

**Credit Card:** If you are making your payment by credit/debit card, please complete the following:

VISA  MASTERCARD  AMERICAN EXPRESS

Card number: \_\_\_\_\_

CSC # (card security) code: \_\_\_\_\_ Expiration date: \_\_\_\_\_

I authorize Ascension Benefits & Insurance Solutions to charge my payment to my credit card in the amount of \$ \_\_\_\_\_

Print name (as on card): \_\_\_\_\_

**Cardholder signature:** \_\_\_\_\_