

Boxing, Kickboxing, Mixed Martial Arts, Wrestling & Toughman Competitions *Insurance*



Boxing, Kickboxing, Mixed Martial Arts, Wrestling & Toughman Competitions Insurance

For many years now, our firm has been a leading provider of sports insurance throughout the nation. Baseball leagues, Tackle Football Camps, Martial Arts Studios... no activity has ever been too risky.

DHC Insurance, L.L.C. is proud to offer our Accident and Liability insurance products for amateur and professional boxing and martial arts bouts. Coverage is extremely affordable and the benefits surpass other insurance providers. Enrollment is easy with our simple application, and with "per event" rates you know *exactly* how your insurance cost is calculated.

With in-house policy issuance, our firm is able to email or fax confirmation of your coverage to any of the state boxing commissions within one hour if needed.

PART 1 **General Liability *Insurance* Coverage**

Who Is Covered

This program provides protection for the promoters, employees, staff, and volunteers against claims of bodily injury liability, property damage liability, personal and advertising injury liability, and the litigation costs to defend against such claims. There is no deductible amount for this coverage.

Coverage Includes Suits Arising Out Of:

- Injury or death of spectators
- Injury or death of volunteers
- Property damage liability
- Host liquor liability (non-profit)
- All activities necessary to conduct events
- Ownership, use, or maintenance of arena or event areas
- General negligence claims
- Cost of investigation and defense of claims, even if groundless

Exclusions

Claims made by athletic participants, fraudulent or dishonest acts, asbestos liability, assault and battery, punitive or exemplary damages, sexual abuse and molestation, employment related practices, professional liability, total pollution, collapse of temporary structure, fireworks and pyrotechnics, nuclear energy liability, use of saunas, sale/manufacturing/distribution of any athletic equipment, owned auto coverage, medical payments, and liability for occurrences prior to the effective date of coverage. All of the above are subject to the terms and conditions of the policy.

Note: There is no liability coverage for claims arising out of any of the following activities: Gymnastics, Cheerleading Pyramids, Trampolines or Inflatable Devices, Waterslides, White Water Rafting, Water Craft, Scuba Diving, Bunjee Jumping, Rock Climbing, Repelling, Ballooning, Parachuting, Rodeo or any other Saddle Animal Exposure.

Program Highlights

- Occurrence Form Policy
- "A" Rated Insuring Company
- No Charge For Additional Insureds
- Low Minimum Premiums For Small Events
- Easy To Complete, One Page Application

This brochure has been designed to illustrate the highlights of this program but is not a contract. Some exclusions and coverages may be modified to meet individual state requirements. For specific details, please view a sample policy.



Enrollment Form for Accident Medical Insurance Toughman Events

Please print or type.

1. Name of Policyholder/Promoter _____

2. Address of Policyholder/Promoter _____
Street City State Zip

Email _____ Phone Number _____

3. Date of Event _____

4. Plan of Benefits & Premium Rates (Check Plan Selected)

Plan Number	Maximum Medical Benefit	Accidental Death Benefit	Deductible	Premium
<input type="checkbox"/> 1	\$2,500.00	\$2,500.00	\$500.00	\$805.00
<input type="checkbox"/> 2	\$5,000.00	\$5,000.00	\$500.00	\$1,125.00
<input type="checkbox"/> 3	\$10,000.00	\$10,000.00	\$500.00	\$2,000.00
<input type="checkbox"/> 4	\$20,000.00	\$50,000.00	\$500.00	\$2,500.00
<input type="checkbox"/> 5	\$50,000.00	\$50,000.00	\$500.00	\$3,000.00

• All above premium rates are per 2-day event

5. Choose one of the following options (payment is required prior to issuance)

Enclosed is my check for the Total Premium

Please bill my Visa / MasterCard / Amex / Discover

_____ exp ____ / ____

6. I understand and agree that if this enrollment form is accepted by the Company, coverage will begin on the date of acceptance or on the date requested in statement 3 (above), whichever is later, subject to the payment of the required premium.

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

Policyholder _____

Title or Position _____ Date Signed _____

Agency Name Agency Email Agency Phone Number

Agency Address _____

Enrollment Form for Liability Insurance Boxing/Mixed Martial Arts Events

Please print or type.

1. Name of Policyholder/Promoter _____
2. Address of Policyholder/Promoter _____
Street City State Zip
Email _____ Phone Number _____
3. Is Policyholder A Corporation An Individual A Partnership Other _____
4. Name and Location of Event _____
Date & Time _____ Seating Capacity _____ Estimated Attendance _____
5. Liability Insurance Limits Requested \$1,000,000.00 Per Occurrence / \$1,000,000.00 Aggregate = \$450.00
 \$1,000,000.00 Per Occurrence / \$2,000,000.00 Aggregate = \$472.50
**Premium rates for up to 1,500 spectators*
6. Have any of the Policyholder's/Promoter's past boxing insurance policies been cancelled or non-renewed in the past? If yes, please give details.

7. Have any of the Policyholder's/Promoter's past boxing insurance policies had claims filed against them? If yes, please give details.

8. Is the Policyholder/Promoter responsible for any of the following:
 Temporary Lighting Tent Security Vendors
 Temporary Stage Ushers Liquor Concessions
Security provider for the event _____
Fire Protection Proximity to Fire/Medical Services _____
Is Facility Protected By Sprinkler System? Yes No
Are Fire Extinguishers Located at Facility? Yes No
9. List any Additional Insureds and relation to the applicant _____

10. Choose one of the following options (*payment is required prior to issuance*)
 Enclosed is my check for the Total Premium
 Please bill my Visa / MasterCard / Amex / Discover
_____ exp _____ / _____

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

Policyholder _____

Title or Position _____ Date Signed _____

Agency Name Agency Email Agency Phone Number

Agency Address _____

Enrollment Form for Accident Medical Insurance Kickboxing/Mixed Martial Arts Events

Please print or type.

1. Name of Policyholder/Promoter _____

2. Address of Policyholder/Promoter _____
Street City State Zip

Email _____ Phone Number _____

3. Date of Event _____

4. Type of Event Kickboxing Mixed Martial Arts

5. Plan of Benefits & Premium Rates (Check Plan Selected)

Plan Number	Maximum Medical Benefit	Accidental Death Benefit	Deductible	Premium
<input type="checkbox"/> 1	\$2,500.00	\$2,500.00	\$500.00	\$770.00
<input type="checkbox"/> 2	\$2,500.00	\$2,500.00	\$1,000.00	\$700.00
<input type="checkbox"/> 3	\$5,000.00	\$5,000.00	\$500.00	\$910.00
<input type="checkbox"/> 4	\$5,000.00	\$5,000.00	\$1,000.00	\$840.00
<input type="checkbox"/> 5	\$10,000.00	\$10,000.00	\$500.00	\$1,400.00
<input type="checkbox"/> 6	\$10,000.00	\$10,000.00	\$1,000.00	\$1,190.00
<input type="checkbox"/> 7	\$20,000.00	\$20,000.00	\$500.00	\$2,750.00
<input type="checkbox"/> 8	\$20,000.00	\$20,000.00	\$1,000.00	\$2,400.00
<input type="checkbox"/> 9	\$25,000.00	\$25,000.00	\$500.00	\$3,162.50
<input type="checkbox"/> 10	\$25,000.00	\$25,000.00	\$1,000.00	\$2,760.00
<input type="checkbox"/> 11	\$50,000.00	\$50,000.00	\$500.00	\$4,250.00
<input type="checkbox"/> 12	\$50,000.00	\$50,000.00	\$1,000.00	\$4,000.00
<input type="checkbox"/> 13	_____	_____	_____	submit for quote

- All above premium rates are per event
- 10 bouts per event limit
- All events are limited to 1 day

6. Choose one of the following options (payment is required prior to issuance)

- Enclosed is my check for the Total Premium
- Please bill my Visa / MasterCard / Amex / Discover
- _____ exp ____ / ____

7. I understand and agree that if this enrollment form is accepted by the Company, coverage will begin on the date of acceptance or on the date requested in statement 3 (above), whichever is later, subject to the payment of the required premium.

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

Policyholder _____

Title or Position _____ Date Signed _____

Agency Name _____ Agency Email _____ Agency Phone Number _____

Agency Address _____

Enrollment Form for Accident Medical Insurance Amateur & Professional Boxing and Wrestling Events

Please print or type.

1. Name of Policyholder/Promoter _____

2. Address of Policyholder/Promoter _____
 Street City State Zip

Email _____ Phone Number _____

3. Date of Event _____

4. Type of Event Boxing Wrestling

5. Plan of Benefits & Premium Rates (Check Plan Selected)

Plan Number	Maximum Medical Benefit	Accidental Death Benefit	Deductible	Premium
<input type="checkbox"/> 1	\$2,500.00	\$2,500.00	\$500.00	\$500.00
<input type="checkbox"/> 2	\$2,500.00	\$2,500.00	\$1,000.00	\$350.00
<input type="checkbox"/> 3	\$5,000.00	\$5,000.00	\$500.00	\$650.00
<input type="checkbox"/> 4	\$5,000.00	\$5,000.00	\$1,000.00	\$600.00
<input type="checkbox"/> 5	\$10,000.00	\$10,000.00	\$500.00	\$1,000.00
<input type="checkbox"/> 6	\$10,000.00	\$10,000.00	\$1,000.00	\$875.00
<input type="checkbox"/> 7	\$20,000.00	\$20,000.00	\$500.00	\$1,450.00
<input type="checkbox"/> 8	\$20,000.00	\$20,000.00	\$1,000.00	\$1,200.00
<input type="checkbox"/> 9	\$25,000.00	\$25,000.00	\$500.00	\$1,595.00
<input type="checkbox"/> 10	\$25,000.00	\$25,000.00	\$1,000.00	\$1,300.00
<input type="checkbox"/> 11	\$50,000.00	\$50,000.00	\$500.00	\$2,500.00
<input type="checkbox"/> 12	\$50,000.00	\$50,000.00	\$1,000.00	\$2,250.00
<input type="checkbox"/> 13	_____	_____	_____	submit for quote

- All above premium rates are per event
- 10 bouts per event limit
- All events are limited to 1 day

6. Choose one of the following options (payment is required prior to issuance)

- Enclosed is my check for the Total Premium
- Please bill my Visa / MasterCard / Amex / Discover

_____ exp ____ / ____

7. I understand and agree that if this enrollment form is accepted by the Company, coverage will begin on the date of acceptance or on the date requested in statement 3 (above), whichever is later, subject to the payment of the required premium.

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

Policyholder _____

Title or Position _____ Date Signed _____

Agency Name Agency Email Agency Phone Number

Agency Address _____

PART 2

Participant Accident Insurance Coverage

Who Is Covered

All participants are covered while participating in Policyholder sponsored and supervised boxing, kickboxing, or wrestling events. A participant is also covered while traveling, directly and without interruption, to and from any Policyholder sponsored activity and his or her home or place of residence.

Maximum Medical Expense Benefit

If the Covered Person incurs eligible expenses as the result of a covered injury, the Company will pay the charges incurred for such expense within 1 year, beginning on the date of accident. Payment will be made for eligible expenses in excess of any other applicable insurance, not to exceed the Maximum Medical Expense Benefit. The first such expense must be incurred within 60 days after the date of the accident.

“Eligible Expenses” means charges for the necessary medical treatment and service, not to exceed the Maximum Medical Expense Benefit as indicated on the following pages.

Excess Coverage: This plan does not cover treatment or service for which benefits are payable or service is available under any other insurance or medical service plan available to the Insured Person.

Accidental Death & Dismemberment

If a covered injury results in any of the losses specified below within one year after the date of the accident, the company will pay the applicable amount.

- Full Principal Sum for loss of life
- Full Principal Sum for double dismemberment
- Full Principal Sum for loss of sight of both eyes
- 50% of the Principal Sum for loss of one hand, one foot, or sight of one eye
- 25% of the Principal Sum for loss of index finger and thumb of same hand

“Member” means hand, foot, or eye. Loss of hand or foot means complete severance above the wrist or ankle joint. Loss of eye means the total, permanent loss of sight. If the Principal Sum is payable, no indemnity will be paid for dismemberment. In any event, the Double Dismemberment Indemnity is the maximum amount payable under this Benefit for all losses resulting from one accident.

Exclusions and Limitations

This plan does not cover any loss to or resulting from:

- intentional self-inflicted injury, suicide while sane or insane or any attempt thereat (in Missouri this applies only while sane);
- voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of the Insured Person’s Physician;
- participation in a riot or insurrection;
- an act of declared or undeclared war;

- active duty service in any Armed Forces of any country, and, in such event, the prorata unearned premium will be returned upon proof of service. This does not include Reserve or National Guard active duty or training unless it extends beyond 31 days;
- parachuting, except for self preservation;
- bungee jumping, flight in an ultralight aircraft, hang gliding;
- sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning;
- services or treatment rendered by a Physician, Nurse, or any other person who is:
 - employed or retained by the Policyholder; or
 - is the Insured Person or an Immediate Family Member;
- flight in an aircraft, except as a fare-paying passenger;
- dental treatment, except as otherwise provided, and only when Injury occurs to sound natural teeth;
- any loss for which benefits are paid under state or federal worker’s compensation, employers liability, or occupational disease law;
- treatment in any Veteran Administration or Federal Hospital, except if there is a legal obligation to pay;
- cosmetic surgery, except for reconstructive surgery due to a covered injury;
- charges the Insured Person would not have to pay if He did not have insurance;
- eyeglasses, contact lenses, hearing aids;
- charges that are in excess of Usual, Customary, and Reasonable charges.

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We provide our clients with a level of service and professionalism that is unparalleled in this field.

Prompt, precise, and professional service has always been the standard at DHC Insurance, L.L.C., and nothing less should be expected.



Extended Claim Service

DHC Insurance, L.L.C. realizes the first and foremost reason a Policyholder purchases insurance is that in the event a claim should arise, that claim is processed in a swift and professional matter. With this understanding, all claims are processed through a partnership with The Loomis Company of Wyomissing, Pennsylvania.

Claim forms are supplied in any quantity at no additional charge. All claim forms have filing instructions and a toll free (888) number for claim inquiries or filing help. Copies of all EOB's (explanation of benefits) and denial letters will be sent to the appropriate Policyholder official or agent. Monthly claim detail reports for each Policyholder will also be mailed.

Policyholder officials and agents will also be provided with an internet address to which they may access using any internet browser such as AOL, Internet Explorer or Netscape. At this website they will be able to use a policy-specific user name and password to view claim information. Information includes names of claimants received, provider information and outstanding amounts, paid amounts and any information requests such as, a need for a completed claim form, or an

itemized medical bill from a provider.

Average claim turnaround time is approximately five to ten days. No pre-certification will be necessary for claimants that must undergo surgery or other similar treatments. If a claimant or physician needs to verify benefits before treatment, that claimant or physician can contact the claims office, the appropriate agent, or the plan underwriter.

The claims office is a participating member of multiple preferred provider networks including 10 national networks, 85 individual PPO's, 3,000 hospitals, and 500,000 physicians. A claimant is not required to seek treatment from physicians or hospitals that also participate with one of these organizations.

A claimant is encouraged to seek treatment at the most convenient location of his or her choice. However, when a claimant visits a physician who is a participating member, it results in a 10% – 30% reduction of the medical bills. Most hospitals and major physician offices are members of one of these preferred provider organizations. When filing a claim there are no special requirements or procedures, everything is processed by the claims personnel.

Underwritten by Starr Indemnity & Liability Company, a Starr International Company subsidiary "A" (Excellent) rated by A.M. Best Company



DHC Insurance, L.L.C.

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