



TEAM INSURANCE COVERAGE

FOR ALL AMATEUR PLAY AND PRACTICE

Includes *General Liability & Accidental Medical Insurance Plans*

EFFECTIVE AUGUST 1ST, 2021 THROUGH AUGUST 1ST, 2022

Coverage will follow all players listed on the NSA Team Waiver or NSA Online Roster for all amateur play for NSA associated events. Coverage follows players for non-NSA associated events as long as the event organizer accepts NSA/Westpoint Insurance.

Teams should contact the organizer of the event to ensure they accept the policy.

PROGRAM HIGHLIGHTS

Proper insurance is a concern of **ALL NSA Teams and Leagues**

INSURANCE PROTECTION

Any kind of legal action is incredibly expensive even if you are innocent or a lawsuit is frivolous. Softball leagues and teams are certainly not exempt from lawsuits and they simply cannot afford to be without adequate liability insurance protection.

The NSA Program offers liability coverage to each team/league as they participate in all sanctioned amateur softball competitions and other related scheduled activities of the sanctioned league. Covered activity means an event sanctioned by the NSA or any other sanctioning body.

\$100,000 ACCIDENTAL MEDICAL COVERAGE - EXCESS

Accidents happen, and with today's soaring medical costs, they can ruin an injured player financially. The NSA Program offers \$100,000 of excess accident medical insurance for each covered injury which pays the bills left unpaid by other collectable insurance of health plans after a \$250 deductible.

GENERAL LIABILITY

WHO IS COVERED?

Coverage is provided for your association, league or team against claims of bodily injury liability, property damage liability and the litigation costs to defend against such claims, even if groundless.

GENERAL LIABILITY LIMITS

\$3,000,000 Each Occurrence /

\$4,000,000 Aggregate

\$1,000,000 Participant Legal Liability

Occurrence means any accident, including continuous or repeated exposure to the same general harmful conditions. Aggregate limit is the maximum dollar amount which will be paid for all losses in a policy period.

General Liability Coverage Includes:

- ◆ Injury or death of a Participant, Spectator or Volunteer
- ◆ Host liquor liability (nonprofit)
- ◆ Ownership, use or maintenance of fields
- ◆ Activities such as meeting, banquets and fund raisers
- ◆ Activities necessary or incidental to conduct of practices and games
- ◆ Abuse & Molestation (\$100,000)
- ◆ General negligence claims

EXCLUSIONS

You must refer to the policy for complete information on policy exclusions. Your exclusions include, but are not limited to: Terrorism, War, Asbestos, Nuclear Energy, Total Pollution, Total Fireworks/Pyrotechnics, Employment Related Practices, Entertainment Errors & Omissions, Aircraft Liability, Lead Liability, Sale/Manufacture/Distribution of Athletic Equipment, Assault & Battery, Stunt Racing, Collapse of Temporary Structure and Communicable Disease.

PLEASE NOTE: this coverage does not cover your team/league for running or holding tournaments, scrimmages or friendlies.

PREFERRED MEMBERSHIP BENEFITS PROGRAM

Includes *General Liability & Accidental Medical Insurance Plans*

EFFECTIVE AUGUST 1ST, 2021 THROUGH AUGUST 1ST, 2022

ACCIDENTAL MEDICAL

WHO IS COVERED?

Insured persons are team players listed on the official NSA Roster and coaches on record for the team(s) specified on the application.

COVERED ACTIVITY

The NSA Program offers excess accident medical coverage to each team/league as they participate in all amateur softball activities of the team/league.

ACCIDENTAL MEDICAL BENEFITS

If an Insured Person incurs Covered Expenses as a result of an Injury sustained during a Covered Activity, the plan will pay 100% of those Covered Expenses after a deductible of **\$250**. Covered Expenses are charged for medically necessary services or supplies made by a hospital, doctor, laboratory, clinic or pharmacy within one year of the date of injury.

ACCIDENTAL MEDICAL LIMITS

\$100,000 Maximum Medical Benefit per claim

\$250 Deductible per claim

Dental Expense: **\$250** per tooth / per accident to a maximum of **\$1,000**

ACCIDENTAL DEATH & DISMEMBERMENT

If an Insured Person suffers a listed Loss as a result of and within one year of an injury sustained during a Covered Activity, the plan will pay the corresponding payment.

LOSS	PAYMENT
Death	\$5,000
Both hands or feet	\$5,000
Sight of both eyes	\$5,000
One hand or foot and sight of one eye	\$5,000
One hand or one foot	\$2,500
Speech or hearing in both ears	\$2,500
Thumb and index finger of same hand	\$1,250

For more information, contact

WESTPOINT INSURANCE GROUP

Call Toll-Free: 1-800-318-7709 or Fax: 1-708-636-3915

E-mail: sales@westpointinsurance.com

Westpoint - BPA Plans

P.O. Box 1495

Bridgeview, IL 60455-0495

**WESTPOINT
INSURANCE**

GENERAL EXCLUSION & LIMITATIONS

You must refer to the policy for complete policy exclusions. The policy does not cover and no payment will be made for any loss or expense arising out of or resulting from:

- ◆ Self-destruction or an attempt there at while sane or intentionally self-inflicted injury;
- ◆ The attempt by the Insured Person to commit a felony;
- ◆ The Insured Person's being intoxicated;
- ◆ The use by the Insured Person of drugs or narcotics unless used as prescribed by a Doctor for a condition other than drug addiction;
- ◆ War, invasion, acts of foreign enemies, civil war, rebellion, insurrection or insurgencies;
- ◆ Illness or disease, except:
 - 1) As may be specifically provided for in the policy;
 - 2) As may result from an injury;
 - 3) A cardiovascular accident, stroke, or other traumatic event caused by exertion while participating in a Covered Event;
 - 4) The aggravation of a condition, including but not limited to, tendonitis, strains, sprains and other similar conditions caused by exertion while participating in a Covered Event.

ACCIDENTAL DEATH & DISMEMBERMENT EXCLUSIONS AND LIMITATIONS

No benefits are payable under this benefit provision for any loss caused or contributed by:

- ◆ Illness or medical or surgical treatment of illness, including diagnosis;
- ◆ Bacterial infection, except septic infection of and through a wound accidentally sustained;
- ◆ Travel or flight in or descent from any aircraft, unless the Insured Person is a fare-paying passenger on a regularly scheduled flight on a commercial airline;
- ◆ Any of the occurrences listed above in the General Exclusion and Limitations.

ACCIDENTAL MEDICAL BENEFITS EXCLUSIONS AND LIMITATIONS

Covered Expenses will never include and no benefits will ever be payable for any charges which:

- ◆ Exceed the reasonable and customary charge;
- ◆ Are incurred for dental work unless the Insured Person sustains an injury which results in damage to his or her natural teeth;
- ◆ Are incurred for services or supplies not specifically provided for in the policy;
- ◆ Would not have been made in the absence of insurance or which the Insured Person is not legally obligated to pay;
- ◆ Are incurred for cosmetic procedures, unless made Medically Necessary by an injury;
- ◆ Are incurred for eyeglasses, contact lenses or hearing aids or for any examination or fitting related to these devices, unless made Medically Necessary by an injury;
- ◆ Are incurred for care or treatment which is not Medically Necessary to the diagnosis or treatment of an injury;
- ◆ Are incurred for custodial care;
- ◆ Are incurred for treatment of a pre-existing condition;
- ◆ Arise out of any of the occurrences listed above in the General Exclusions and Limitations.

The policy is secondary coverage to all other coverage. This brochure is for illustrative purposes only. It is not a contract of insurance. It is intended to provide a general overview of the program.

Please remember only the insurance policy can give actual terms of coverage. All benefits payable are subject to definitions, limits, maximums, deductible benefit periods and limitations and exclusions of the policy.

PREFERRED MEMBERSHIP BENEFITS PROGRAM APPLICATION

for *General Liability & Accidental Medical Insurance Plans*

EFFECTIVE AUGUST 1ST, 2021 THROUGH AUGUST 1ST, 2022

Name of Organization (i.e. League, Team, etc.) _____

Street Address (Proof of Insurance Sent) _____

City _____ State _____ Zip _____

Contact Person's Name _____ Phone _____

Cell _____ Fax _____

E-mail Address _____ Website Address _____

Requested Effective Date _____

Insured Teams: If you don't have a NSA Sanction Number, go to: www.playnsa.com

Team Name _____ NSA Membership/Sanction Number _____

Team Name _____ NSA Membership/Sanction Number _____

Team Name _____ NSA Membership/Sanction Number _____
(Please list additional teams/sanction numbers on a separate sheet)

Additional Insureds: (i.e. field owners, municipalities, schools, parks, rec centers, etc.)

Name _____ Address _____

City _____ State _____ Zip _____

Name _____ Address _____

City _____ State _____ Zip _____
(Please list additional insureds including address on a separate sheet)

CALCULATE YOUR RATES!

4 TEAMS OR MORE (MUST BE PURCHASED AT THE SAME TIME)

AGE RANGE	NUMBER OF TEAMS	x RATE	=TOTAL PREMIUM
8 & Under		\$111.00	
10 & Under		\$120.00	
12 & Under		\$129.00	
14 & Under		\$136.00	
16 & Under		\$143.00	
18 & Under		\$155.00	
23 & Under		\$162.00	
Adult		\$229.00	
TOTAL			

3 TEAMS OR LESS (MUST BE PURCHASED AT THE SAME TIME)

AGE RANGE	NUMBER OF TEAMS	x RATE	=TOTAL PREMIUM
8 & Under		\$123.00	
10 & Under		\$136.00	
12 & Under		\$146.00	
14 & Under		\$156.00	
16 & Under		\$163.00	
18 & Under		\$178.00	
23 & Under		\$188.00	
Adult		\$265.00	
TOTAL			

Payment Process Options

Note: We no longer can accept payment information by E-mail or fax for security reasons. To remit payment securely by check or credit card, choose one of these secure options below:

- ONLINE** Usually same-day service - allow 24 hours for turnaround.
1. Go to www.playnsa.com to access the secure online application feature.
 2. Fill in the requested information and remit application & payment online instantly.

Allow 7-10 days for mail delivery & processing

- BY MAIL**
1. Print & complete this application
 2. Enclose application, payment info & mail to:
Westpoint Insurance Group
NSA/BPA Plans
P.O. Box 1495
Bridgeview, IL 60455-0495

Pay by: Check Money Order Credit Card
Select Card: VISA Master Card AMEX Discover

Card No. _____ Exp. Date _____ CVS No. _____

Billing Address _____

City _____ State _____ Zip _____

Membership & Coverage begins with receipt of full payment & enrollment request. By signing this application, I hereby verify the information provided herein is true & complete. Premium is fully earned upon certificate issuance. No pro-rata refunds are available.

By signing the application, I agree to terms herein & to allow payment processing using the check or card information indicated.

Authorized Signature _____ Date _____

Title/Position _____