



HIGH INTENSITY FUNCTIONAL FITNESS
APPLICATION AND RISK SURVEY

SUBMISSION REQUIREMENTS

- Completed and signed / dated PHL Y High Intensity Functional Fitness application and risk survey
Currently valued insurance company loss runs for the current policy period plus three (3) prior years
Copy of health club membership application, including waiver language
Copy of maintenance agreements with equipment providers

GENERAL INFORMATION

Applicant:
Mailing address:
Billing address:
Web address:
Type of operation: Individual Partnership Corporation
Contact name: Phone number:
FEIN number: SIC code: Years in business:
Crossfit Affiliate? Yes No
Is there an Accident / Medical Policy in place? Yes No
If yes, what limits are carried (Per Accident)?
None \$5,000 \$10,000 \$25,000 \$50,000 \$100,000 \$1,000,000
Are there procedures in place to verify that individuals and parents carry their own health insurance? Yes No
If the Applicant does not have Accident / Medical coverage, do they need a quote? Yes No

SECTION I - PREVIOUS CARRIER INFORMATION

Table with 4 columns: Carrier, Expiration, Annual Premium. Rows include Property, General Liability, and Crime.

List any property or liability claims in the previous three (3) years:

SECTION II - GENERAL LIABILITY COVERAGE

General Aggregate \$3,000,000 \$2,000,000 \$1,000,000 \$300,000
Products/Comp Ops Agg \$3,000,000 \$2,000,000 \$1,000,000 \$300,000
Personal Injury \$1,000,000 \$1,000,000 \$500,000 \$100,000
Occurrence \$1,000,000 \$1,000,000 \$500,000 \$100,000
Fire Legal \$50,000 \$50,000 \$50,000 \$50,000
Medical Expense \$1,000 \$1,000 \$1,000 \$1,000
Increase Fire Legal limit to: \$ (only if other than \$50,000)
BI/PD deductible: \$250 \$500 \$1,000 Per Occurrence
Hired and Non-Owned coverage limit? Yes No
Umbrella policy limit requested? Yes No If yes, what limit: \$
Employers Liability limits: \$ Employers Liability carrier:
Additional Insured(s)
Lessor of leased equipment:
Lessor of premises:
Mortgagee:

Grantor of franchise:

**SECTION III – PROPERTY SECTION**

**Building(s)**

Loc. No.	Bldg. No.	ACV/RC	Limit of Insurance	Coinsurance	Address
			\$		
			\$		
			\$		
			\$		

**Contents (Includes Improvements & Betterments)**

Loc. No.	Bldg. No.	ACV/RC	Limit of Insurance	Coinsurance	Address
			\$		
			\$		
			\$		
			\$		

Deductible: \$500 \$1,000 Other: \$  
 Business Income: Limit of Insurance: \$ (Monthly Limit of Indemnity Form)  
 Monthly Limitation: 1/3 1/4 1/6

**Construction of building:**

Walls: Wood frame Brick / Brick Steel frame Other:  
 Roof: Wood frame Poured concrete Steel frame Other:  
 Floor: Wood frame Concrete Other:

Year built: Square footage: Age of roof:  
 Does the Applicant have any inflatable, fabric or air supported structures such as, but not limited to bubbles or domes? Yes No  
 Does the property have automatic fire sprinklers? Yes No  
 Distance to: Hydrant: Fire station:  
 Burglar Alarms: Local Central station only w/keys Central station w/o keys  
 Does the property have aluminum wiring? Yes No  
 If yes, has it been retrofitted with one of the PHLI approved connectors and by a licensed electrician? Yes No  
 (Indicate which one): COPALUM? Yes No AlumiConn? Yes No  
 Date updated? **Please supply retro-fit documentation or statement from installing contractor**  
 Does the Applicant own the building? Yes No  
 If no, who does:  
 Mortgagee: Loss Payee:

<b>Signs</b>			
	Type	Value	Location
1.		\$	
2.		\$	

**Flood**  
 Does the Applicant have a current flood policy in force? Yes No  
**If yes, attach a copy of the declarations sheet.**  
 If no, would the Applicant like a flood quote with our proposal? Yes No

**Crime Coverage**

Theft, Disappearance & Destruction  
 Loss Inside the Premises: \$ Loss Outside the Premises: \$  
 Employee Dishonesty: \$  
 Number of officers and employees who have custody of the money:

By whom is financial audit completed: Frequency of audits:  
 Is there a countersignature procedure in place? Yes No  
 Frequency of bank deposits:  
 Are accounts reconciled by someone not authorized to deposit or withdraw monies? Yes No

**SECTION IV – RISK SURVEY QUESTIONNAIRE**

1. Gross sales: \$ Memberships: % Retail: %  
 2. Payroll: \$ Annual Member Fee: \$ Monthly Member fee: \$
- |                           | Up to age 12 | Ages 13 -16 | Age 17 and older |
|---------------------------|--------------|-------------|------------------|
| <b>Total Participants</b> |              |             |                  |
4. Number of employees: Management: Physical Therapy: Personal Trainers:  
 Administrative: Other:
5. Number of sub-contractors: Services sub-contracted:
6. Are certificates of insurance obtained from the Applicant's sub-contractors? Yes No  
 If yes, provide a copy.
7. Is the Applicant looking to provide coverage for any of the above under the policy? Yes No  
 If yes, who:
8. How many personal trainers are employed / sub-contracted at the Applicant's facility:
9. How many of the personal trainers are Crossfit certified:
10. Any property leased to others? If yes, explain: Yes No
- Please provide square footage leased:
11. Any events held off premises by the Applicant? If yes, explain: Yes No
12. Number of guests per month:
13. Are guests required to sign waiver of liability forms? Yes No
14. Do all members sign a waiver of liability form prior to receiving membership? Yes No
15. Are medical disclosure forms requested of all members? Yes No
16. Is an incident log kept of all injuries and accidents? Yes No
17. Are all guests and members instructed on how to use equipment on a continuing basis? Yes No
18. Is a pre-workout evaluation done by a fitness trainer for new members? Yes No
19. Are exercise instructions and demonstrations given on each exercise and WOD? Yes No
20. Are all workouts monitored? N/A Yes No  
 Are members permitted to train without supervision? Yes No
21. Are showers and locker rooms present? Yes No
22. If yes, are there non-slip surfaces in shower areas? Yes No
23. How many Automatic External Defibrillators (AED) does the Applicant have at each location?
24. How many employees at each location are trained to operate an AED?
25. Was full CPR training included with the AED training? Yes No
26. What are the Applicant's hours of operation:
27. Is staff present during all hours of operation? Yes No
28. Is there a snack bar or restaurant on the premises? Yes No  
 If yes, square footage occupied:
29. Is there a bar serving liquor? Yes No  
 If yes, square footage occupied:
30. Is there any volunteer labor or "free membership / work exchange"? Yes No
31. Is there a pro shop? Yes No  
 If yes, square footage occupied:
32. Are any products sold with the Applicant's name or label on them? Yes No
33. Are dietary supplements sold? Yes No  
 If yes, what brand names:
34. Are Crossfit Kids programs run at this facility? Yes No
35. Who is responsible for equipment installation (ropes, pull up bars, etc)?

## SECTION V - CONCUSSIONS - ATHLETICS

- |   |           |            |                       |
|---|-----------|------------|-----------------------|
| 1. Does the Applicant have a written concussion awareness and management program in place, and, where applicable, is it compliant with current state legislation?   | Yes       | No         |                       |
| If yes, does this include:  |           |            |                       |
| a. Understanding a concussion and the potential consequences of this injury?  | Yes       | No         |                       |
| b. Recognizing the signs and symptoms of a concussion or other closed head injury and how to respond?   | Yes       | No         |                       |
| c. Learning about steps for returning to activity after a concussion?   | Yes       | No         |                       |
| d. Focusing on prevention and preparedness to help keep participants safe?  | Yes       | No         |                       |
| <b>*A copy of written program is required upon binding.</b>   |           |            |                       |
| 2. Does the insured require all coaches, instructors, and officials to complete the online Concussion Course offered by the Centers for Disease Control and Prevention?   | Yes       | No         |                       |
| 3. a. Does the insured communicate and distribute education materials to participants and / or parents / guardians of minors about the nature of risk of concussions, including but not limited to how to recognize concussion symptoms, in written or electronic form? | Yes       | No         |                       |
| b. Does the insured require the participants and / or parents / guardians of minors to sign an acknowledgment that they have received and reviewed?   | Yes       | No         |                       |
| 4. If a concussion is suspected, does the Applicant require the participant to leave the game or practice immediately?  | Yes       | No         |                       |
| 5. Does the Applicant mandate that participants suspected of suffering a concussion can only return after at least 24 hours and with written clearance from a licensed physician before being allowed to return to play?  | Yes       | No         |                       |
| 6. Does the Applicant utilize base line testing?  | Yes       | No         |                       |
| 7. Does the Applicant currently utilize any concussion impact monitoring technology?  | Yes       | No         |                       |
| If yes:   |           |            |                       |
| a. Describe:  |           |            |                       |
| b. Advise the name of the manufacturer:   |           |            |                       |
| c. Advise who monitors the data:  |           |            |                       |
| Coaches   | Employees | Volunteers | 3 <sup>rd</sup> Party |

## SECTION VI - FACILITIES AND SERVICES

**(Supply an inventory list with values where applicable)**

Free weights:	lbs.	Masseuse / Masseur	Yes	No
Lifecycles: #		Is this sub-contracted?	Yes	No
Rowing machines: #		Aerobics	Yes	No
Step machines: #		Is this sub-contracted? (please attach a schedule)	Yes	No
Tires: #		Martial Arts	Yes	No
Treadmills: #		Is this sub-contracted?	Yes	No
Rock climbing apparatus: #		Running program off premises?	Yes	No
Sledgehammers: #		Physical therapists	Yes	No
Rings: #		Is this sub-contracted?	Yes	No
Climbing ropes: #		Number of therapists:		
Box Platforms: #				
Steam room/Sauna: #				
Sleds: #				
Tennis Bubbles: #	sq. ft =			
Circuit equipment (balls, bars, kettlebells): # of pieces:			sq. ft.=	

**SECTION VII - ABUSE AND MOLESTATION**

**N/A**

- |     |  |     |    |
|-----|--|-----|----|
| 1.  | Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? | Yes | No |
| 2.  | Does the Applicant's state permit criminal background investigations?<br>If yes, does the Applicant routinely request and receive such background investigations?  | Yes | No |
| 3.  | Does the Applicant verify employment-related references?   | Yes | No |
| 4.  | Does the Applicant conduct a personal interview?   | Yes | No |
| 5.  | Does the Applicant have written procedures for dealing with sexual abuse?<br><b>If yes, attach a copy.</b>   | Yes | No |
| 6.  | Will any independent contractors have access to children / clients or perform operations where they will be physically touching another person?<br>If yes:<br>a. Please explain:   | Yes | No |
|     | b. Does the Applicant perform background checks on hired independent contractors?  | Yes | No |
| 7.  | Does the Applicant have a plan of supervision that monitors staff in day-to-day relationships with clients, both on and off premises?  | Yes | No |
| 8.  | Has the Applicant ever had an incident which resulted in an allegation of sexual abuse?<br>If yes, please describe:  | Yes | No |
|     | a. Was a claim made against the Applicant?   | Yes | No |
|     | b. Was the case settled?   | Yes | No |
|     | c. Was the case taken to trial?  | Yes | No |
|     | d. How much money was paid as damages to the victim: \$  |     |    |
| 9.  | Regarding coverage for Abuse & Molestation, does the Applicant's current policy:<br>Exclude coverage<br>Limit coverage (please indicate limit): \$<br>Neither exclude or limit coverage                                    |     |    |
| 10. | Please indicate age range of clients:      From:                      To:  |     |    |

**FRAUD STATEMENT AND SIGNATURE SECTIONS**

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company \* in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

\*Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company

**VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.**

**FRAUD NOTICE STATEMENTS**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS (\$5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PA, RI, TN, VA, VT, WA AND WV).**

**APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV:** ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

**APPLICABLE IN COLORADO:** IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

**APPLICABLE IN FLORIDA AND OKLAHOMA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

**APPLICABLE IN KANSAS:** AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

**APPLICABLE IN KENTUCKY:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

**APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**APPLICABLE IN PENNSYLVANIA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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NAME (PLEASE PRINT/TYPE)

TITLE  
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

**SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT**

PRODUCER  
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER  
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)

## CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

Name of Applicant:  
 Address of Applicant:  
 City: State: Zip:  
 Website: www:  
 Nature of Operations:

1. Annual sales or revenue: \$
  
2. Does the Applicant collect, store or otherwise handle any Personally Identifiable Information (PII) belonging to customers, clients, or other third parties, other than employees? Yes No  
 If yes, please indicate the types of Personally Identifiable Information held (check all that apply):
  - a. Social Security Numbers, Bank or Other Financial Account Details, Driver's License or other State Identification Numbers
  - b. Non-public Medical or Healthcare Data, including Protected Health Information (PHI)
  - c. Credit or Debit Card Information
  
3.
  - a. During the last three (3) years, has anyone alleged that the Applicant was responsible for damage to their computer system(s) arising out of the operation of the Applicant's computer system(s)? Yes No
  - b. During the last three (3) years, has anyone made a demand, claim, complaint, or filed a lawsuit against the Applicant alleging invasion or interference of rights of privacy or the inappropriate disclosure of Personally Identifiable Information (PII)? Yes No
  - c. During the last three (3) years, has the Applicant been the subject of an investigation or action by any regulatory or administrative agency for privacy-related violations? Yes No
  - d. Is the Applicant aware of any circumstance that could reasonably be anticipated to result in a claim being made against them for the coverage being applied for? Yes No

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