



USA TRACK & FIELD  
**VOLUNTEER EVENT MEDICAL PROFESSIONAL LIABILITY**  
PROGRAM SUMMARY



**COVERAGE HIGHLIGHTS:**

- **IN ORDER TO APPLY FOR COVERAGE, THE EVENT MUST BE SANCTIONED THROUGH USA TRACK & FIELD.**
- **CARRIER:** The program is underwritten by Lexington Insurance Company, rated "A" (*Excellent*) by A.M. Best.
- **EVENT MEDICAL PROFESSIONAL LIABILITY COVERAGE:** Volunteer Event Medical Professional Liability Claims-Made coverage for volunteer physicians and all other volunteer healthcare providers providing support to participants, volunteers and spectators during sanctioned events.
- **NAMED INSURED:** USA Track & Field; Volunteer physicians and all other volunteer healthcare providers providing services in connection with sanctioned events enrolled in the **Volunteer Event Medical Professional Liability Program**. Event Organizers are included as insureds under the policy.
- **PRIOR ACTS COVERAGE:** Prior acts are covered provided there are no current pending claims, and the insured is not aware of any circumstance which could give rise to a claim, subject to applicable Retro Date.
- **ERP/TAIL COVERAGE:** Tail coverage is included as long as the master policy is in force. An automatic Extended Reporting Period of 1 year will apply after the termination of the program (provided the program has been in force for a minimum of three years).
- **LIMITS OF LIABILITY:** The policy is written with limits of \$1,000,000 per claim and \$3,000,000 aggregate (per event) subject to a **minimum** annual policy aggregate of \$5,000,000.
- **DEFENSE COSTS:** Coverage for defense is provided **in addition** to the applicable policy limits.
- **DEDUCTIBLE:** \$0 Deductible
- **OTHER INSURANCE CLAUSE:** **The volunteer event medical professional liability coverage is secondary to any other available coverage, but is primary in the event that no other coverage exists. Volunteer physicians and all other volunteer healthcare providers will not be required to provide evidence of other insurance as a condition of enrollment.**

**ELIGIBILITY REQUIREMENTS:**

- **ELIGIBLE EVENTS:** Coverage is provided for USA Track & Field Sanctioned Events that have submitted the required Enrollment Form and remitted the appropriate premium to USA Track & Field.
- **ELIGIBLE PERSONS:** All volunteer physicians and all other volunteer healthcare providers, including doctors (all specialties), physician assistants, chiropractors, nurses, EMT's/paramedics, athletic trainers, physical therapists, and massage therapists. Volunteer physicians and all other volunteer healthcare providers who receive a small stipend and/or expense reimbursement are eligible for coverage under the program.
- **CREDENTIALING/LICENSEING REQUIREMENTS:** The volunteer physicians and all other volunteer healthcare providers must be licensed (in good standing) in the state where they normally practice/work. There is not a requirement to be licensed in the state where the event takes place.

**RATE STRUCTURE:**

Rates include all premiums, fees and surplus lines taxes.

Y Volunteer Physicians	\$56.00
Y All Other Volunteer Healthcare Providers	\$20.00

**ENROLLMENT/APPLICATION PROCESS:**

- **ENROLLMENT (BY EVENT):** The Event Organizer will submit the completed Enrollment Form and the applicable premium to USA Track & Field postmarked within 48 hours after the completion of the sanctioned event.

**ENROLLMENT FORM:** Each event will submit a final list of all volunteer physicians and all other volunteer healthcare providers using the attached Enrollment Form. The form must be postmarked within 48 hours after the completion of the event. The form requires the name and specialty for each volunteer physician and all other volunteer healthcare provider. By completing the form, each volunteer physician and all other volunteer healthcare provider is certifying that he/she is a duly licensed, certified, or registered in the state where he/she is authorized to perform services within scope of practice. The name and specialty of each volunteer physician and all other volunteer healthcare provider must be listed for coverage to apply.

**To Request or Submit an Enrollment Form:**

USA Track & Field  
Attn: Carmen Triplet - Ph: (317) 261-0500  
132 East Washington Street, Suite 800  
Indianapolis, IN 46204

**For Coverage Questions:**

Entertainment & Sports Insurance eXperts (ESIX)  
Attn: Stephanie Kleinfelter - Ph: (678) 324-3300  
5660 New Northside Drive, Suite 640  
Atlanta, GA 30328



**USA TRACK & FIELD  
VOLUNTEER EVENT MEDICAL PROFESSIONAL LIABILITY  
ENROLLMENT FORM**



NAME OF EVENT: \_\_\_\_\_ EVENT DATES: \_\_\_\_\_ EVENT SANCTION # \_\_\_\_\_

THE NAME AND SPECIALTY OF EACH VOLUNTEER PHYSICIAN AND ALL OTHER VOLUNTEER HEALTHCARE PROVIDER MUST BE LISTED IN ORDER FOR COVERAGE TO APPLY.

	PRINT NAME	SPECIALTY - CHECK ONE:	
		DOCTORS/ PHYSICIANS*	ALL OTHERS HEALTHCARE**
		(SEE DESCRIPTIONS BELOW)	
1		<input type="checkbox"/>	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>
3		<input type="checkbox"/>	<input type="checkbox"/>
4		<input type="checkbox"/>	<input type="checkbox"/>
5		<input type="checkbox"/>	<input type="checkbox"/>
6		<input type="checkbox"/>	<input type="checkbox"/>
7		<input type="checkbox"/>	<input type="checkbox"/>
8		<input type="checkbox"/>	<input type="checkbox"/>
9		<input type="checkbox"/>	<input type="checkbox"/>
10		<input type="checkbox"/>	<input type="checkbox"/>
11		<input type="checkbox"/>	<input type="checkbox"/>
12		<input type="checkbox"/>	<input type="checkbox"/>
13		<input type="checkbox"/>	<input type="checkbox"/>
14		<input type="checkbox"/>	<input type="checkbox"/>
15		<input type="checkbox"/>	<input type="checkbox"/>
16		<input type="checkbox"/>	<input type="checkbox"/>
17		<input type="checkbox"/>	<input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>
23		<input type="checkbox"/>	<input type="checkbox"/>
24		<input type="checkbox"/>	<input type="checkbox"/>
25		<input type="checkbox"/>	<input type="checkbox"/>
26		<input type="checkbox"/>	<input type="checkbox"/>
27		<input type="checkbox"/>	<input type="checkbox"/>
28		<input type="checkbox"/>	<input type="checkbox"/>
29		<input type="checkbox"/>	<input type="checkbox"/>
30	<b>TOTAL:</b>	<input type="checkbox"/>	<input type="checkbox"/>

**ALL VOLUNTEER PHYSICIANS AND ALL OTHER VOLUNTEER HEALTHCARE PROVIDERS MUST BE LICENSED (IN GOOD STANDING) FOR COVERAGE TO APPLY.**

\*DOCTORS SHALL INCLUDE ALL MEDICAL PRACTITIONERS, RESIDENT PHYSICIANS, CHIROPRACTORS AND OTHER LICENSED PHYSICIANS IN ALL SPECIALTIES.

\*\*ALL OTHER VOLUNTEER HEALTHCARE PROVIDERS SHALL INCLUDE PHYSICIAN ASSISTANTS (PA), NURSES, EMERGENCY MEDICAL TECHNICIANS (EMT), PARAMEDICS, ATHLETIC TRAINERS, PHYSICAL THERAPISTS, AND MASSAGE THERAPISTS.

**READ & SIGN:** I UNDERSTAND THAT THE INSURANCE COMPANY WILL RELY ON THE INFORMATION CONTAINED IN THIS FORM AND ALL OTHER INFORMATION BEING SUBMITTED. I HEREBY WARRANT, REPRESENT AND CONFIRM THAT, TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION PROVIDED IS COMPLETE, TRUE AND CORRECT.

**NAME OF EVENT ORGANIZER/REPORTING PARTY:** \_\_\_\_\_

**BY CHECKING THIS BOX, I AGREE THAT I AM THE ABOVE LISTED PARTY.**



**USA TRACK & FIELD  
VOLUNTEER EVENT MEDICAL PROFESSIONAL LIABILITY  
ENROLLMENT FORM**



**PAYMENT INFORMATION:**

EVENT NAME: \_\_\_\_\_

EVENT DATE(S): \_\_\_\_\_

EVENT SANCTION #: \_\_\_\_\_

EVENT ORGANIZER/REPORTING PARTY: \_\_\_\_\_

**TOTAL COST SUMMARY:**

TOTAL # OF VOLUNTEER PHYSICIANS :	
TOTAL # OF ALL OTHER VOLUNTEER HEALTHCARE PROVIDERS :	
<b>\$56.00 x # OF VOLUNTEER PHYSICIANS =</b>	<b>\$</b>
<b>\$20.00 x # OF ALL OTHER VOLUNTEER HEALTHCARE PROVIDERS =</b>	<b>\$</b>
<b>TOTAL AMOUNT DUE:</b>	<b>\$</b>

**PAYMENT PREFERENCE:**

**CHECK OR MONEY ORDER:** (PLEASE MAKE CHECK PAYABLE TO USA TRACK & FIELD)

ENCLOSED IS CHECK # \_\_\_\_\_ FOR \$ \_\_\_\_\_

**CREDIT CARD:** (VISA ONLY) *FOR THIS FORM OF PAYMENT, CONTACT USATF - CARMEN TRIPLET - PH: (317) 261-0500*

**ACH:** *FOR THIS FORM OF PAYMENT, CONTACT USATF - CARMEN TRIPLET - PH: (317) 261-0500*

**MAILING INSTRUCTIONS:**

**PLEASE MAIL YOUR COMPLETED ENROLLMENT FORM WITH PAYMENT TO:**

USA TRACK & FIELD  
ATTN: CARMEN TRIPLET  
132 EAST WASHINGTON STREET, SUITE 800  
INDIANAPOLIS, IN 46204  
PH: (317) 261-0500  
FAX: (800) 833-1466  
[CARMEN.TRIPLET@USATF.ORG](mailto:CARMEN.TRIPLET@USATF.ORG)

**ENROLLMENT FORM AND PREMIUM MUST BE POSTMARKED WITHIN 48 HOURS AFTER THE COMPLETION OF THE EVENT.**