



March 2018

**Young Marines  
Regiments & Units**  
*Attn: Commanding Officer*

Re: Commercial General Liability Insurance  
Group Accident Insurance  
Effective: March 2018-2019

Dear Commanding Officer:

We are pleased to enclose your Certificate of Insurance along with a Summary of Coverages.

The Certificate of Insurance should be retained in your files permanently. If you are required to provide evidence of insurance and/or add another party as an "Additional Insured", please complete the *Special Event Questionnaire (Certificate of Insurance Request Form)* and return to Rust Insurance Agency. Alternatively, you can complete the questionnaire online at [www.rustinsurance.com/ym.pdf](http://www.rustinsurance.com/ym.pdf). Any contract that you sign should be reviewed for insurance requirement – adding an Additional Insured requires underwriting approval.

It is important that the exclusions and restrictions listed in the summary be noted. *If a planned event falls into any of these areas, please notify us immediately.*

This general liability insurance is designed to protect you against claims alleging negligence that cause injuries to third parties (persons other than members) – it does not cover suits brought against a member by another. This is not and was never intended to be an accident policy for the members. Please refer to the separate Accident Policy in place for the Young Marines.

**PLEASE NOTE:** ALL CLAIMS, INCLUDING ACCIDENT MEDICAL EXPENSES MUST BE REPORTED AND SUBMITTED TO THE YOUNG MARINES NATIONAL HEADQUARTERS. DO NOT SEND THEM TO RUST INSURANCE AGENCY.

Should you have any questions, please give us a call at **1-800-235-1889, ext. 5013**. It is always a pleasure to be of service.

Sincerely,

*Billy*  
William P. Simons, IV  
President

WS4/smp  
Enclosures

**YOUNG MARINES**  
**National Headquarters, Regiments and Units**  
17739 Main Street, Suite 250  
Dumfries, VA 22026

**SUMMARY OF COVERAGES**  
March 13, 2018 to March 13, 2019

**COMMERCIAL GENERAL LIABILITY**

***Philadelphia Indemnity Insurance Company Policy #PHPK1776289***

\$3,000,000. General Aggregate Limit  
\$3,000,000. Products-Completed Operations Aggregate  
\$1,000,000. Personal and Advertising Injury Limit  
\$1,000,000. Each Occurrence Limit  
\$ 100,000. Fire Damage Limit (any one fire)  
\$ 5,000. Medical Expense Limit (any one person)

**UMBRELLA LIABILITY**

***Philadelphia Indemnity Insurance Company Policy #PHUB617561***

\$2,000,000. Each Occurrence  
\$2,000,000. Products/Completed Operations  
\$2,000,000. Aggregate Limit  
\$ 10,000. Deductible

**Including:**

- *Members as Additional Insured*  
- *Volunteers as Additional Insured*  
- *Abuse or Molestation*

- *Managers or Lessors of Premises  
as Additional Insured*

**Excluding:**

- *Injury to Participants*  
- *Workers' Compensation/Camps or Campgrounds*  
- *Automobile Liability*  
- *Professional Liability*

- *Employers' Liability*  
- *Employment Practices Liability*  
- *Athletic or Sports Participants*  
- *Lead Exclusion/Punitive Damage/Asbestos*  
- *Pollution/Nuclear Energy Liability*

**IMPORTANT:** *The Certificate of Insurance issued to you should be retained permanently in your files as evidence of your coverage. If you are required to provide evidence of insurance and/or add another party as "Additional Insured" in the policy, please complete the "Special Event Questionnaire/Certificate of Insurance Request Form" and return to Rust Insurance Agency. Any contracts you sign must be reviewed for their insurance requirement – adding an Additional Insured requires underwriting approval.*

**NOTES:**

1. The limit of liability is **shared** by units, battalions, regiments, divisions, and National Headquarters.
2. Medical Expense coverage does not extend to Members and Volunteers nor does Members and Volunteers as Additional Insureds cover bodily injury to these individuals.
3. The Young Marines has a separate Accident Policy in place for its Registered Adults.
4. Certificate of Insurance should be obtained from anyone providing services to you (caterers, bus charters, contractors and professional service providers). **Have the Young Marines listed as an Additional Insured.**
5. **NO** business contents or property coverage is provided to the units and regiments.
6. This is a summary of the coverages provided. The actual coverage descriptions, conditions, and exclusions are in the original policy on file at the National Headquarters.

**FOR QUESTIONS OR ASSISTANCE, PLEASE CONTACT:**

RUST INSURANCE AGENCY, LLC  
1510 H Street NW, 5<sup>th</sup> Floor  
Washington, DC 20005  
Attn: William P. Simons, IV  
E-mail: [wsimons@rustinsurance.com](mailto:wsimons@rustinsurance.com)

## **GROUP ACCIDENT POLICY**

Insured: **YOUNG MARINES**  
Address: 17739 Main Street, Suite 250  
Dumfries, VA 22026  
Policy #: PTPN00719936  
Effective Date: October 1, 2017 to October 1, 2018  
Company: Chubb/ACE American Insurance Company  
COVERAGE Applies to those Insured Persons included under Class I who are participating in policyholder's activity. Subject to all other terms of the policy, the insurance company will cover injury to the Insured while:

- taking part in a sponsored activity; or
- traveling directly to or from such activity.

### **INSURED PERSONS**

Class I All dues-paying Members and Registered Adults whose names are on file and taking part in the activity sponsored and supervised by the Young Marines.

### **BENEFITS**

Class I \$20,000. Accidental Death and Dismemberment  
\$10,000. Medical Expense (\$100 Deductible)

Aggregate Limit of Liability in one accident: \$750,000.

THIS IS A SUMMARY OF THE COVERAGES PROVIDED. FOR ACTUAL TERMS, CONDITIONS AND EXCLUSIONS, PLEASE REFER TO THE POLICY ON FILE.

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### **IMPORTANT NOTICE**

**TO FILE A CLAIM, PLEASE COMPLETE THE FOLLOWING FORMS:**

- *Young Marine Injury Report Form*
- *Proof of Claim - Accident Medical Expense*
- *Attending Doctor's Statement*

**PLEASE RETURN THE FORMS TO:** **Young Marines National Headquarters**  
Attn: Patricia Borka, Director of Administration  
17739 Main Street, Suite 250  
Dumfries, VA 22026

**TO ENSURE PROMPT PAYMENT, COMPLETED FORMS MUST BE SUBMITTED WITHIN 30 DAYS OF ACCIDENT/INJURY. IF NOT YET AVAILABLE, ACTUAL HOSPITAL BILLS/STATEMENTS CAN BE FORWARDED SEPARATELY UPON RECEIPT.**

Client#: 20690

YOUA2

ACORD™

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

2/28/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER: Rust Insurance Agency, LLC; CONTACT NAME: Billy Simons; PHONE: 202 776-5013; FAX: 202 776-1286; INSURED: Young Marines National Headquarters; INSURER(S) AFFORDING COVERAGE: Philadelphia Indemnity Insurance Co., Chubb/ACE American Insurance Company

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

Table with columns: INSR LTR, TYPE OF INSURANCE, POLICY NUMBER, POLICY EFF (MM/DD/YYYY), POLICY EXP (MM/DD/YYYY), LIMITS. Includes rows for General Liability (PHPK1776289), Umbrella Liability (PHUB617561), Workers Compensation, and Group Accident (PTPN00719936).

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER IS NAMED INSURED - Subject to policy terms, conditions and exclusions

CERTIFICATE HOLDER: YOUNG MARINES NATIONAL HEADQUARTERS REGIMENTS AND UNITS; CANCELLATION: SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE: [Signature]

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**YOUNG MARINES**  
**SPECIAL EVENT QUESTIONNAIRE**  
**(CERTIFICATE OF INSURANCE REQUEST FORM)**

REGIMENT/UNIT: \_\_\_\_\_  
MAILING ADDRESS: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_  
DAYTIME PHONE #: ( ) \_\_\_\_\_  
FAX NUMBER: ( ) \_\_\_\_\_

1. Describe Event: \_\_\_\_\_  
*(Training/Drills, Meeting/Seminar, Encampment, Picnic, etc.)*
2. Are you the sponsor? \_\_\_\_\_ If NO, name of main sponsor: \_\_\_\_\_
3. Date(s) of event: \_\_\_\_\_
4. Address of event: \_\_\_\_\_
5. Estimated attendance: \_\_\_\_\_ No. of Exhibitors: \_\_\_\_\_
6. Admission to be charged: \$ \_\_\_\_\_ Expected gross receipts: \$ \_\_\_\_\_
7. Will event be held indoors or outdoors? \_\_\_\_\_
8. Have you conducted similar events in the past? \_\_\_\_\_ If YES, have there been any claims/losses? \_\_\_\_\_
9. Describe past claims/losses, if any: \_\_\_\_\_
10. Describe security to be provided: \_\_\_\_\_
11. Describe first aid to be provided: \_\_\_\_\_
12. Will there be amusement rides or fireworks? \_\_\_\_\_
13. Describe refreshments planned: \_\_\_\_\_
14. Are they complimentary or purchased? \_\_\_\_\_
15. Are you serving the alcohol or contracting the service out? \_\_\_\_\_
16. Describe any cooking to be done: \_\_\_\_\_
17. **Does another party need a Certificate of Insurance other than what you already have? \_\_\_ If Yes, list name:**  
Name: \_\_\_\_\_  
Attn: \_\_\_\_\_  
Address: \_\_\_\_\_  
Tel No: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_
18. Does the other party require "**ADDITIONAL INSURED**" wording? \_\_\_ If YES, describe their interest: *(landlord, owner of premises, lessor, event sponsor, etc.)* \_\_\_\_\_
19. Have you agreed to "**HOLD HARMLESS**" the other party? \_\_\_\_\_ *(attach a copy of your contract, permit, or agreement)*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTES:**

- ◆ If a contract, permit or agreement has been signed, please attach a copy for review.
- ◆ If possible, please allow up four weeks for processing.

**PLEASE RETURN COMPLETED QUESTIONNAIRE TO:** RUST INSURANCE AGENCY, LLC  
1510 H Street, NW, 5<sup>th</sup> Floor  
Washington, DC 20005  
  
Attn: William P. Simons, IV  
E-mail: [wsimons@rustinsurance.com](mailto:wsimons@rustinsurance.com)  
Fax: (202) 776-1286 or (202) 776-1282  
Tel: (202) 776-5000  
Toll Free: 1-800-235-1889, ext. 5013



## INJURY REPORT

PLEASE PRINT

**COMPLETE AND SEND COPY TO:**  
 Young Marines National Headquarters  
 17739 Main Street, Suite 250  
 Dumfries, VA 22026-3256  
 Fax: (202) 889-0502  
 Email: patriciaborka@youngmarines.com

**PLEASE SUBMIT INJURY REPORT TO YMNHQ WITHIN 30 DAYS OF ACCIDENT  
 INJURY REPORT AND ATTENDING PHYSICIAN'S STATEMENT FORMS MUST ACCOMPANY CLAIMS TO BE SUBMITTED TO HSR BY CLAIMANT**

| PART I – INJURED PERSON'S PERSONAL INFORMATION   |                           |                            |                |
|--|---------------------------|----------------------------|----------------|
| LAST NAME  | FIRST NAME                | MIDDLE INITIAL             |                |
| AGE  | BIRTHDATE<br>(MM/DD/YYYY) | SOCIAL SECURITY NUMBER     |                |
| HOME ADDRESS<br>Street   |                           | City                       | State      Zip |
| PARENT/GUARDIAN NAME   |                           | RELATIONSHIP               |                |
| PRIMARY TELEPHONE NUMBER   |                           | SECONDARY TELEPHONE NUMBER |                |
| Was the parent or legal guardian notified of the injury?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                           |                            |                |
| Was hospital/emergency care required?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                    |                           |                            |                |
| If YES, please include Attending Physician's Statement and all documents.  |                           |                            |                |

| PART II – YOUNG MARINES UNIT INFORMATION |  |  |                        |          |
|--|--|--|------------------------|----------|
| YOUNG MARINES UNIT NAME                  |  |  | STATE                  | DIVISION |
| UNIT COMMANDER'S NAME                    |  |  |                        |          |
| UNIT COMMANDER'S PRIMARY PHONE NUMBER    |  |  | SECONDARY PHONE NUMBER |          |
| UNIT COMMANDER'S EMAIL                   |  |  |                        |          |

| PART III – DESCRIBE INJURY & CIRCUMSTANCES SURROUNDING INJURY  |                            |                                |
|--|----------------------------|--------------------------------|
| PROVIDE A SHORT DESCRIPTION OF THE INJURY OR INJURIES:<br>_____<br>_____<br>_____<br><div style="text-align: right;">(Use additional pages as needed)</div>  |                            |                                |
| DATE OF INJURY   | APPROXIMATE TIME OF INJURY | LOCATION WHERE INJURY OCCURRED |
| PROVIDE A SHORT DESCRIPTION OF HOW THE INJURY OCCURRED: (Who, What, Why, and How)<br>_____<br>_____<br>_____<br>_____<br>_____<br><div style="text-align: right;">(Use additional pages as needed)</div> |                            |                                |

| PART IV – UNIT COMMANDER OR REGISTERED ADULT IN CHARGE CERTIFICATION  |      |                             |
|---|------|-----------------------------|
| <i>I certify this injury occurred during a scheduled Young Marines activity and that the injury was not pre-existing and the activities did not involve undue risk outside the scope of the Young Marines Accident and Liability Insurance coverage. To the best of my knowledge, the information provided is correct and true.</i> |      |                             |
| UC/RAC SIGNATURE<br>X   | DATE | UC/RAC PRIMARY PHONE NUMBER |

| PART V – YMNHQ REVIEW AND PROCESSING |  |   |                                 |
|--------------------------------------|--|---|---------------------------------|
| DATE REPORT WAS RECEIVED             | PHYSICIAN'S STATEMENT ATTACHED<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | HSR CLAIM FORM ATTACHED<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | DATE SIGNED CLAIM FORM RETURNED |
| DATE OF FOLLOW-UP REMARKS:           |  | DATE OF FOLLOW-UP REMARKS:  |                                 |





# ATTENDING PHYSICIAN'S STATEMENT

PLEASE PRINT

**COMPLETE AND SEND COPY TO:**  
Young Marines National Headquarters  
17739 Main Street, Suite 250  
Dumfries, VA 22026-3256  
Fax: (202) 889-0502  
Email: patriciaborka@youngmarines.com

PLEASE SUBMIT INJURY REPORT TO YMNHQ WITHIN 30 DAYS OF ACCIDENT

***INJURY REPORT AND ATTENDING PHYSICIAN'S STATEMENT FORMS MUST ACCOMPANY CLAIMS TO BE SUBMITTED TO HSR BY CLAIMANT***

| PATIENT'S INFORMATION |                           |                        |           |
|-----------------------|---------------------------|------------------------|-----------|
| LAST NAME             | FIRST NAME                | MIDDLE INITIAL         |           |
| AGE                   | BIRTHDATE<br>(MM/DD/YYYY) | SOCIAL SECURITY NUMBER |           |
| HOME ADDRESS          |                           |                        |           |
| Street                |                           | City                   | State Zip |
| PARENT/GUARDIAN NAME  |                           | RELATIONSHIP           |           |
| PRIMARY PHONE         |                           | ALTERNATE PHONE        |           |

| PART I - TO BE COMPLETED BY ATTENDING PHYSICIAN   |        |      |
|---|--------|------|
| Complete section below in full or attach a complete itemized statement of charges and statement of diagnosis.   |        |      |
| I hereby authorize <b>Health Special Risk, Inc.</b> or its representative, to inspect all x-ray pictures, clinical records and to obtain full information, including etiology, diagnosis and prognosis, or other data that may be in your possession or under your control, to make copies of the same or any portion thereof, pertaining to the subject patient. |        |      |
| Attending Physician Signature<br>X  | Degree | Date |

| PART II - STATEMENT OF ATTENDING PHYSICIAN/DENTIST   |  |
|--|--|
| 1. DIAGNOSIS (Describe nature of injury or illness):<br>_____<br>_____<br>_____  |  |
| 2. Is the condition the result of <input type="checkbox"/> illness or <input type="checkbox"/> injury? (Check appropriate box)      What date did the illness commence or injury occur?                                    |  |
| 3. Has the patient had treatment for the same or related condition before? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown (Check appropriate box)<br>If YES, when and by whom?  |  |
| 4. On what date were you first consulted for this condition?<br>Give date(s) of treatment(s): In Office: _____ At Home: _____  |  |
| 5. If hospitalized, give name and address of hospital and dates of in-patient care.<br>Name of Hospital: _____ Hospital Phone: _____ Dates: (From/To) _____<br>Hospital Address: _____ City: _____ State: _____ Zip: _____ |  |
| 6. If surgery was performed, please describe:<br>_____<br>_____<br>_____   |  |
| 7. Prognosis:<br>_____<br>_____<br>_____   |  |

|  |  |                                  |           |
|--|--|----------------------------------|-----------|
| Physician's Name (Please Print)        |  | Social Security or Tax ID Number |           |
| Address of Attending Physician/Dentist |  |                                  |           |
| Street                                 |  | City                             | State Zip |
| Attending Physician's Signature<br>X   |  |                                  | Date      |