**Liability Application for Fitness Trainers & Instructors**

P.O. Box 2009, Glen Allen, VA 23058-2009
Telephone: (800) 900-1155; Fax (804) 273-6144
Email applications to: sportsandfitness@markelcorp.com
markelfitness.com

***Important Note: All trainers and instructors must be currently certified by a U.S. national board. This policy does not provide injury or damage coverage arising out of premises you own, rent, or occupy, or arising out of the sale of any type of product. You must be 18 years of age or older.***

Applicant: _____ Business Name: _____

Phone #: (____)_____ Fax #: (___)_____ Email: _____

Mailing Address: _____ City: _____County: _____

State: _____ Zip Code: _____Website: _____

Contact Person & Phone Number: _____

## Section 1 – General Information

1. Effective Date Desired: _____
2. Please select your primary discipline(s): ☐ Personal Trainer ☐ Aerobics-Individual/Group ☐ Yoga ☐ Pilates ☐ Dance ☐ Cardio Kickboxing ☐ Dancersize/Jazzercise ☐ StrollerFit/Strides ☐ Water Aerobics ☐ Zumba®
3. Entity: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ LLC ☐ Other (indicate)_____
4. Name of facility where you work: _____

   Facility Address: _____

   City: _____ State: _____ Zip: _____
5. Does this facility require a certificate of insurance? ☐ Yes ☐ No
6. Have you ever applied for insurance with Markel Insurance Company? ☐ Yes ☐ No Policy #, if applicable: _____
7. Has a medical or liability claim been made against you in the last 5 years? ☐ Yes ☐ No **(If Yes, attach a letter explaining all details.)**
8. Have you signed a lease to rent space for your business? ☐ Yes ☐ No

## Section 2 - Program & Training Information

1a. Do you carry a current U.S. certificate in the area of your expertise? ☐ Yes ☐ No

b. Are you accredited by the following organizations? ☐ W.I.T.S

2. Do you have clients complete a health history form including all of the following: health conditions, allergies, and medications, OR are you willing to start requiring a signed health history form? ☐ Yes ☐ No
3. Do you or your employer (if not self-employed) have a waiver with wording that has been reviewed by an attorney in your state that is signed by parent/guardian, or participant of legal age OR are you willing to start requiring an attorney approved signed waiver? ☐ Yes ☐ No

   **NOTE: You must keep your clients' health history forms and waivers for a minimum of 6 years. Please have these forms available upon request.**
4. Are you a massage therapist or do you administer massage therapy? ☐ Yes ☐ No

5a. Other than group activities of those primary disciplines listed at the top of the application are you involved in other activities? ☐ Yes ☐ No

b. If yes, please provide details (up to 250 characters):_____

_____

6. Do you employ personal trainers or instructors other than yourself? ☐ Yes ☐ No If yes, how many? _____

**NOTE: You will be charged an individual premium plus any applicable taxes and fees for each employee.**

**IMPORTANT: IT IS MANDATORY THAT YOU OBTAIN CURRENT CERTIFICATES OF INSURANCE FOR INDEPENDENT CONTRACTORS.**

7. If your certification includes Nutritional/Dietary Supplement training and for an additional charge per person would you like coverage for Nutritional & Dietary Supplement Consulting coverage? ☐ Yes ☐ No

**Limit of Liability requested:**

☐ $500,000 (Premium - $136 fully earned)

☐ $1,000,000 (Premium - $171 fully earned)

☐ $2,000,000 (Premium - $195 fully earned)

**Nutritional & Dietary Supplement Consulting Coverage**

☐ $100,000 occurrence / $100,000 aggregate (Premium- $25 fully earned)

The premium is a per person premium and is fully earned as allowed by states. Taxes and fees will be added where they apply.

**Please send my insurance policy by:** ☐ E-mail *(Be sure to complete the email address at the top of this application.)*

☐ **Please mail me my policy. (Allow 7-10 business days.)**

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Coverage shall not be bound until the company approves the applicant's completed application and premium payment is received. The company's receipt of premium does not bind coverage until the completed application is also approved. In the event the company does not approve your application, your premium payment will be refunded.

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed: _____ Date:_____/_____/_____

**To charge full amount to MasterCard/VISA, please complete the following:**

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number* : _____-_____-_____-_____

Expiration Date: _____/_____ Credit Card Verification # _____

Cardholder Name: _____
*(Please print)*

Your Name: _____
*(If different from Cardholder Name)*

*Application requiring credit card information must be completed, printed, signed and faxed (or mailed) into our office. For your security, we request credit card information not be emailed.

Cardholder Billing Address: _____

Billing City: _____ Billing State: _____ Billing ZIP: _____

Signature: _____

To pay full amount by check:

Please mail your payment, with your completed application, to:

Markel
Sports & Fitness
P.O. Box 2009
Glen Allen, VA 23058-2009

Submit