



Concessionaires, Exhibitors & Vendors Liability Enrollment Form

This Form must be completed, signed and returned with your payment. The submission of this enrollment form does not guarantee coverage. Completion of this enrollment form confirms you desire to obtain insurance through the Sports, Leisure and Entertainment Risk Purchasing Group. Certain operations are not eligible for coverage by this program. CSI reserves the right to decline any request for coverage. TO AVOID DELAYS, PLEASE TYPE OR PRINT LEGIBLY.

Insured Name _____

Trade Name _____

Mailing Address (no PO Box, please) _____

City _____ State _____ Zip _____

Contact Name _____

Phone: _____ Fax: _____ Cell Phone: _____

Email: _____ Web Site: _____

Form of business: Individual Partnership/Joint Venture Limited Liability

Company Trust Other

Number of years you have been in business as a vendor:

Provide a list or description of the products you sell, handle or display in your operations:

Which of the following best describes the area in which you conduct the operations to be

insured: ___ Trailer-If Patrons enter the trailer, give the dimensions: ___ ft. by ___ ft.

___ Food Trailer-Number of trailers utilized at one time _____

___ Game Trailer- Number of Games utilized at one time _____

___ Tent, give the dimesions: ___ ft. by ___ ft.

___ Kiosk, Give the dimensions: ___ ft. by ___ ft.

___ Push Cart, Number of Carts utilized at one time _____



___ Out door Area, give the dimensions: ___ ft. by ___ ft.

___ Other, describe and give the dimensions: _____

What is the height of the booth or display, including any attached or free-standing signage? _____ ft. If the display is higher than 12 feet at any point, provide a photograph of the display.

Event Information: (Single Event Coverage)

Name of event:

Date(s) of Event: _____ Hours of event: _____ am/pm to _____ am/pm

Location of Event:

a. Venue Name:

b. Address:

City / State / Zip:

Additional Insured – An Additional Insured is any person, landlord or organization requiring you to list them as additional insured

Additional Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: Landowner / Manager of Premises Sponsor Organizer of Event

Fax Agent: CSI Entertainment – 800 590 3211

IF MORE THAN ONE ADDITIONAL INSURED, PLEASE LIST ON SEPARATE SHEET.

* Premiums are 100% Fully Earned At Inception and Non-refundable.



Six Month Or Annual Coverage. If applying for this, please answer the following:

New or Renewal: I am a former insured returning to CSI I am a new account for CSI
 I am renewing my coverage with CSI

2. Desired effective dates: Start: _____ End:

Note: Coverage will not be made effective prior to the date that the enrollment form and payment are received by CSI.

3. Number of shows you will attend during the coverage period: _____

4. Do you attend more than one show simultaneously? ____ Yes ____ No

5. Additional Insured- Please use a separate sheet to request additional entities.

Name of event:

Date(s) of Event:

Location of Event:

a. Venue Name:

b. Address:

City / State / Zip:

Additional Insured – An Additional Insured is any person, landlord or organization requiring you to list them as additional insured

Additional Insured: _____

Address: _____

City: _____ State: _____ Zip: _____



Relationship: Landowner / Manager of Premises Sponsor Organizer of
Event

Fax Agent: CSI Entertainment – 800 590 3211.

Warranty Statement

I understand that the insurance company, in determining whether to provide coverage 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. I further acknowledge that I have reviewed all information provide with this enrollment form and understand the exclusions that apply, as wells as the activities and operations for which coverage is not provided.

I am aware that the insurance company expects accurate reporting for my premium calculation, and should my figures exceed my estimates during the coverage term I will make arrangements to pay the additional premium. I understand that my books and records may be examined or audited by the insurance company at any time during the coverage period and up to three years afterwards. Intentional misrepresentation or misreporting may jeopardize coverage.

I further acknowledge that, I have reviewed all information provided with this enrollment form and understand the exclusions which apply, as well as the activities and operations for which coverage is not provided.

Signature: _____ Printed Name: _____

Title: _____

Date: _____