



# PARTICIPANT ACCIDENT DRIVING SCHOOL APPLICATION

## 1. APPLICANT INFORMATION

Legal Name: \_\_\_\_\_ Doing Business As: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Website: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Insured is:  Corporation  Partnership  Joint Venture  Other: \_\_\_\_\_  
 Policy Period Requested: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 Nature of operations/description of event: \_\_\_\_\_  
 Standard Industrial Classification (SIC) if known: \_\_\_\_\_

## 2. OPERATIONS

Type of Group:  Team  Track  Association  Club  Employer

Activities to be covered:

*While participating in sponsored, supervised, and scheduled driving school and ride-a-long activities of the Policyholder for which premium has been paid.*

Covered Persons:

*All registered driving school participants and ride-a-long participants of the Policyholder*

*Program/Package	Avg. # Enrolled	Avg. # Laps	Track Length	Avg. Speed	Max Speed

*\*(i.e., Rookies, Stock Car, Advanced, Performance, Formula Car, etc.)*

## 3. COVERAGE REQUESTED – (Check the type of coverage and indicate the limits desired):

Accidental Death & Dismemberment:

\$5,000  \$10,000  \$15,000  \$20,000  \$25,000  Other: \_\_\_\_\_

Medical Excess (*Pays EXCESS to any other valid & collectible insurance*):

\$10,000  \$15,000  \$20,000  \$25,000  \$50,000  Other: \_\_\_\_\_

Weekly Indemnity: \_\_\_\_\_ Primary Medical: \_\_\_\_\_

**WSIB Motorsports Insurance, 950 W Monroe St. Suite G200, Jackson, MI 49202**  
**www.wsibinsurance.com**

It is understood that the Insurance company in determining whether to provide a quotation for insurance coverage will rely on the information contained in the application and all other information being submitted.



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## 4. GENERAL INFORMATION

Is there currently a plan in force?:  Yes  No If Yes: Current Carrier: \_\_\_\_\_

Period	Premium	Incurred Losses	# of Losses

Participation: *This is a mandatory program.*

Premium Remittance (request):  Annually  Quarterly  Other: \_\_\_\_\_

I understand that the insured company in determining whether to provide a quotation for insurance coverage will rely on the information contained in the application 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.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Producer's Signature (if applicable)

\_\_\_\_\_  
Applicant's Name (print)

\_\_\_\_\_  
Producer's Name (print)

\_\_\_\_\_  
Date (MM/DD/YY)

\_\_\_\_\_  
Date (MM/DD/YY)

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