

APPLICATION FOR EVENT CANCELLATION

Please Print or Type

1. INSURED: Association or Organization holding Event

Name _____
Address _____
City _____ State _____ Zip _____
Telephone () _____ Facsimile () _____ E-mail _____

2. EVENT TO BE INSURED

TYPE:

___ CONVENTION/MEETING ___ With Exhibits ___ Without Exhibits ___ With Teleconferencing
___ TRADE SHOW/EXPOSITION ___ Open to the Public ___ Not Open to the Public
___ CONSUMER SHOW ___ Event dependent upon 2 or less speakers

OTHER TYPE OF EVENT Details: (Provide a separate attachment if necessary)

Full Name of Event: _____

Open Dates of Event: From _____ to _____ (inclusive)

Is any part of the event to be held in the open, in a tent or in any structure of a temporary nature? ___ Yes ___ No

3. EVENT FACILITY

Name _____
Address _____
City _____ State _____ Zip _____

Do written contracts exist between you and the facility? ___ Yes ___ No

Please confirm you have made all the necessary preliminary arrangements essential to ensure that a satisfactory event can be held on the scheduled date. ___ Yes ___ No

4. FINANCIAL INFORMATION

a. Please provide the following information about the event to be insured.

___ BUDGETED GROSS REVENUE: \$ _____ ___ BUDGETED EXPENSES: \$ _____

___ BUDGETED NET INCOME: \$ _____

b. Does the Gross Revenue stated above represent the entire Gross Revenue of the event and not a portion? ___ Yes ___ No

c. At any time during the past 5 years have you had an event that suffered a Loss that was covered by insurance? ___ Yes ___ No

5. PRE-EXISTING POTENTIAL LOSS

Are you aware of any circumstances existing or threatened, that may possibly result in a claim under the insurance? If the answer to this question is yes, provide full details on a separate attachment. ___ Yes ___ No

NOTE: If you become aware of any such circumstances after completing this application and before the date insurance of the Convention commences, you must disclose the circumstance to the insurers immediately to see if the insurance will be affected.

PLEASE READ AND SIGN BELOW

Signing this Application and Declaration does not bind the applicant or the company to complete the Insurance, but it is agreed that this Application and Declaration shall be attached to and form part of any policy which may be subsequently issued.

I declare that the statements and estimates made herein after due inquiry are true to the best of my knowledge and belief.

Name _____ Signature **X** _____
(Please print) (As authorized person for and on behalf of the INSURED)

Title _____ Date _____

Return this application to:

WALTERRY INSURANCE BROKERS

7411 OLD BRANCH AVENUE, CLINTON, MARYLAND 20735

301-868-7200 800-638-8791 FAX 301-868-2611 insurance@walterry.com <http://www.walterry.com>