

Combative Sports Accident Medical Application

NAME: _____ DBA: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: () _____ FAX () _____

DATE OF EVENT: _____ LOCATION (CITY): _____

TYPE OF EVENT: _____ NUMBER OF SCHEDULED BOUTS: _____

COMMISSIONER: _____ FAX NUMBER: _____

AMOUNT OF COVERAGE/DEDUCTIBLE? (20K/20K W/ \$500 DED.) _____

DATE PREMIUM WAS SENT & HOW? (1-1-01/ FED EX) _____

VISA – MASTERCARD: (CIRCLE ONE) EXPIRATION DATE: _____

CARD #: _____

ADDRESS ON CREDIT CARD ACCT.: _____

AUTHORIZED SIGNATURE: _____

LAURENCE COLE INSURANCE AGENCY

**P.O. BOX 600183
DALLAS, TX 75360**

**6060 N. CENTRAL EXPWY., SUITE 232
DALLAS, TEXAS 75206**

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