

1. APPLICANT (Association or Organization Holding Event)

Please Print or Type

Name _____
 Address _____
 City _____ State _____ ZIP _____ Website _____
 Telephone () _____ Fax () _____ Email _____
 Please check if you are a member of the following Associations: AMC ASAE IAEE MPI

2. EVENT TO BE INSURED

- a. EVENT: 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 keynote speaker(s)?

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

- b. Full Name of Event _____
 c. Open Dates of Event From _____ To _____ (inclusive of lease dates)
 d. 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
 If "Yes," please provide full details on a separate attachment.

3. EVENT FACILITY

- Name _____
 Address _____
 City _____ State _____ ZIP _____
 a. Do written contracts exist between you and the Facility? Yes No
 b. 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. Do the Gross Revenue/Expenses stated above represent the entire Gross Revenue/Expenses of the Event and not a portion? Yes No
 c. At any time during the past five years, have you had an event that suffered a loss that was covered by insurance? Yes No

5. PREEXISTING 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 Event 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 underwriter to complete the insurance, but it is agreed that this Application and Declaration shall be attached to and form part of any policy that 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 APPLICANT)

Title _____ Date _____

PLEASE SIGN AND RETURN COMPLETED FORM IN THE ENCLOSED ENVELOPE TO:

Association Member Benefits Advisors (AMBA) ■ 4050 NW 114th Street ■ Urbandale, IA 50322

Or fax to: 1-312-627-6172. If you have any questions, please call toll-free: 1-877-451-4003.

AR Ins. Lic. #100114462 • CA Ins. Lic. #0196562

Association Member Benefits Advisors, LLC.

In CA d/b/a Association Member Benefits & Insurance Agency