SOUTHERN CALIFORNIA MUNICIPAL ATHLETIC FEDERATION

OFFICIATING LIABILITY INSURANCE PROGRAM APPLICATION

CERTIFICATE HOLDER (CITY/AGENCY INFORMATION)

Name: ____

Address: ____

City: ______________________________ State: ________ Zip: ______________

Phone: ______________________________ Fax: ______________________________

ADDITIONAL INSURED (OFFICIAL'S INFORMATION)

Name: ____

Address: ____

City: ______________________________ State: ________ Zip: ______________

Phone: ______________________________ Email: ______________________________

Special wording as required by city/agency, if any: ______________________________

____

PROGRAM DETAILS (IF APPLICABLE)

Name of Program Director: ____

Phone: ______________________________ Email: ______________________________

Location: ____

Please provide the following:
A copy of contractual agreement between city/agency and location.
A copy of the waiver and release form between the group and the participants.
Date and Location of SCMAF Certified Official's Training:

PAYMENT AMOUNT: __$45 per official* __$165 Waiver of Subrogation __ $160 SAM Coverage (Sexual Abuse & Molestation)

(______) Pay App (______) Bill Agency (______) Credit Card (Please contact SCMAF Office to make payment)

Applicant's Signature: Date: ____

Print Name: ____

Program Director's Signature (if applicable): ______________________________

Title: ____

*certificate good for calendar year (expires 12/31)

Mail or Fax Application and Materials to SCMAF:
SCMAF Officiating Liability Insurance Program
P.O. Box 3605
South El Monte, CA 91733
(626) 753-1975
BillBant@scmaf.org