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.)_____

AMBULANCE COVERAGE ($120.00 Additional) YES/NO: _____

DATE PREMIUM WAS SENT & HOW? _____

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

CARD #: _____VCODE#:_____

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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