



Child Care Supplemental Application

Proposed effective date: _____

Name insured: _____ DBA: _____

(If multiple named insureds, please complete the additional named insured schedule below)

Phone #: _____ Fax #: _____ Email: _____

Mailing address: _____ City: _____

County: _____ State: _____ Zip code: _____ Website: _____

Contact person & phone number: _____

Section 1 – Applicant information

1. Type of entity: Corporation Individual Partnership Joint venture LLC Other: _____

2. Date business started under current ownership: _____

(If you have in business less than 3 years include a copy of your resume, financials or a bank letter of credit.)

3. Do you conduct criminal background investigations on all employees and volunteers? Yes No

If no, explain: _____

4. Do you have a formal, documented abuse policy in place including regular staff training on reporting incidents, identifying symptoms or signs of abuse, and a minimum of 2 staff present at all times with children? Yes No

If no, explain: _____

If yes, does the abuse policy include regular staff training on reporting incidents? Yes No

If yes, does the abuse policy include training on identifying symptoms of abuse or signs of abuse? Yes No

5. Do you offer more than 12 field trips annually? Yes No

If yes, what is the average number of field trips each year for all locations? _____

6. Are any field trips overnight? Yes No

Section 2 – Additional named insured schedule

Please complete the following for each additional named insured:

Name: _____	
<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Joint venture <input type="checkbox"/> LLC <input type="checkbox"/> Other: _____	
More than 50% common ownership?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	
<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Joint venture <input type="checkbox"/> LLC <input type="checkbox"/> Other: _____	
More than 50% common ownership?	Yes No
Name: _____	
<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Joint venture <input type="checkbox"/> LLC <input type="checkbox"/> Other: _____	
More than 50% common ownership?	Yes No

Section 5 – Description of operations (Complete this section for each location. Please copy as necessary.)

Location #: _____

Location address: _____

1. Is this location a for-profit or not-for-profit organization? For-profit Not-for-profit
2. Describe the operations at this location:
 Child care center Before/after school child care Montessori Headstart Pre-K nursery
 Drop in child care Sick child care
Explain care provided for drop in or sick child operations: _____
3. Which describes the building you occupy?
 Basement in residence Multiple occupancy building Church building Converted dwelling
 Single occupancy building School building Strip mall Other: _____
4. Do any of the following apply to this location? Check all that apply
 - a. Building leased to others Square footage leased: _____
Is this building maintained by the insured? Yes No
 - b. Office Square footage: _____ Is this building maintained by the insured? Yes No
 - c. Vacant land Number of acres: _____
 - d. Warehouse (separate from child care) Square footage: _____
Type of warehouse: Private Mini warehouse
 - e. Other: _____
5. Are all child care operations at this location licensed? Yes No
If yes, complete the licensing supplemental and provide a copy of your license)
If no, explain: _____
Non-licensed child care average attendance: _____
6. Are you accredited by any of the following?
 AELL NAEYC NECPA NAA Other: _____
Does the organization provide loss control services? Yes No
7. Are your hours of operation more than 6 hours a day? Yes No
8. Do you provide overnight care? Yes No
(If yes, complete the overnight care section of the miscellaneous care supplemental)
9. What is your average daily number of infants? (18 months or younger) _____
10. Are children with special needs cared for at this location? Yes No
(If yes, complete the special needs section of the miscellaneous care supplemental)
11. Do you have a swimming pool on premises? Yes No
12. Are any swim or water activities provided at any off-premises pools, oceans, lakes, or water parks? Yes No
(If yes, complete the water activities supplemental)
13. Is there a playground at this location? (If yes, complete the playground supplemental) Yes No

Section 6 – Property information (Complete this section for each location. Please copy as necessary.)

Location #: _____

Location address: _____

1. Deductible: \$1,000 \$2,500 \$5,000 \$10,000

2. Coinsurance: 80% 90% 100%

3. Is the building built specifically for child care operations? Yes No

Year built: _____

4. Please list updates to the building for each of the following:

Roof: _____ Plumbing: _____ Electrical: _____ HVAC: _____

Type of roof: Composite/ asphalt shingle Metal Rubber Slate Wood Other: _____

If any updates over 15 years for roof or 20 years on other, please explain reasoning: _____

5. Do you own the building at this location? Yes No

6. Is the building sprinklered? Yes No

7. Building square footage: _____

8. Is this structure a trailer, modular, or prefabricated building? Yes No

9. Number of stories: _____

Coverage	Limit	Valuation (*RC or ACV)	Construction	Occupancy
Building				
Personal property of the insured				
Tenants improvements & betterments				
Business income			N/A	
Fence				N/A
Sign				N/A
Playground equipment				N/A
Awning or canopy				N/A

*RC = Replacement Cost; ACV = Actual Cash Value

10. Does a separate business income coinsurance apply? Yes No

Coinsurance %: _____

11. Business income monthly limit of indemnity: 1/3 1/4 1/6

12. Is this location adjacent to potentially hazardous exposures? Yes No

If yes, describe: _____

Section 7 – Additional interest schedule (Complete this section for each location. Please copy as necessary.)

Location #: _____

Location address: _____

Name: _____ Address: _____ Interest is: <input type="checkbox"/> Mortgagee <input type="checkbox"/> Lender's loss payee <input type="checkbox"/> Loss payee <input type="checkbox"/> Building owner <input type="checkbox"/> Other: _____
Name: _____ Address: _____ Interest is: <input type="checkbox"/> Mortgagee <input type="checkbox"/> Lender's loss payee <input type="checkbox"/> Loss payee <input type="checkbox"/> Building owner <input type="checkbox"/> Other: _____

Section 8 – Licensing supplemental (Complete this section for each location. Please copy as necessary.)

Location #: _____

Location address: _____

1. Expiration date of license: _____
2. Is the license currently suspended or revoked? Yes No
 License capacity: _____
3. Average daily attendance (based on 12 months): _____
4. Date of the most recent state inspection: _____
5. Are there any citations for any violations in the most recent state inspection? Yes No
 If yes, please indicate the type of state inspection violations that apply to the most recent inspection:
 - a. Child to staff ratios? Yes No
 - b. Fire drills? Yes No
 - c. Inappropriate discipline of children? Yes No
 - d. Playground cover? Yes No
 - e. Transportation? Yes No
 - f. Any other violation, which may result in the harm of a child? Yes No

If you answered yes to any of the above, explain each violation and provide corrective action taken:

Section 9 – Playground supplemental (Complete this section for each location. Please copy as necessary.)

Location #: _____

Location address: _____

1. Does the facility have its own play area? Yes No
 If "No", skip to Section 11.
2. Is the play area fenced? Yes No
3. Please indicate the type of surface the permanently installed play equipment over 18 inches high:
 Asphalt Cement Course sand Double-shredded mulch Engineered wood fibers Fine gravel
 Fine sand Medium gravel Shredded tires Wood chips Other: _____
4. Is the depth of the playground surface at least 6 inches? Yes No
 If no, explain: _____

5. Was the equipment installed by, or has it been inspected by, someone certified in playground safety? Yes No
6. How often are regular maintenance and routine inspections performed on the equipment?
- Daily Weekly Monthly Every other month Quarterly Semi-annually Annually
7. Does the center have playground equipment with a primary platform over 6 feet high and/or any apparatus over 8 feet high? Yes No

Section 10 – Water activities supplemental (Complete this section for each location. Please copy as necessary.)

Location #: _____

Location address: _____

1. Off-premises On-premises N/A
2. Please select any type of "off premises" water exposure that apply:
- Public pool Private pool Wading pool (pool with normal depth of 18 inches or less) Lake Ocean
- Waterpark: Number of trips to the waterpark per year: _____
- a. Do you maintain the same staff/child ratio on trips as you do in the classroom? Yes No
- b. Provide complete details including frequency and minimum age:

3. For "on premises" swimming pools:
- a. Number of pools at this location (do not include wading pools): _____
- b. Use of pool: operated year round operated less than 12 months
- If operated less than 12 months. How many months is the pool used? _____
- If operated less than 12 months, what is the percentage of supervised activities? _____
- c. Are swimming pools and in-ground wading pools completely fenced with at least a 4 foot fence with self-locking gates? Yes No
- d. Do all pool drains and grates have covers in place and are they in compliance with Virginia Graeme Baker Pool and Spa Safety Act? Yes No
4. For all water activities:
- a. Are all activities staffed with certified life guard(s)? Yes No
- b. Is the staff always present and are they trained in water safety including CPR? Yes No
- c. Are permission slips including waiver of subrogation obtained for all children participating in the water activities? Yes No
- d. Are children allowed to use water slides and/or diving boards? Yes No
- If yes, are the water slides and/or diving boards located in a water park? Yes No

Section 11 – Business auto supplement

1. FEIN/Social security number: _____
2. Are your vehicles ever used to transport persons other than your center's children? Yes No
If yes, explain: _____
3. Do you provide transportation other than to/from schools and field trips? Yes No
If yes, explain: _____
4. Are all the vehicles on the vehicle schedule titled to or leased to the name insured? Yes No
If no, explain: _____
5. Do you allow drivers under the age of 21 transport children? Yes No
If yes, explain: _____
6. What is the estimated annual mileage per vehicle? Less than 5,000 5,001 to 7,000 Over 7,000
7. Which of the following controls do you have in place to prevent a child from being left in your vehicle:
 - a. Headcount at departure & return? Yes No
 - b. Headcount upon vehicle exit? Yes No
 - c. Headcount at destination? Yes No
 - d. Written procedures? Yes No
 - e. Other: _____
8. Does the estimated percentage of personal use for each vehicle exceed 25%? Yes No
If yes, describe: _____
9. Questions for private passenger type vehicles only:
 - a. Are private passenger vehicle(s) used to transport children? Yes No
 - b. Does the primary driver of the vehicle(s) have their own personal auto insurance? Yes No
Who is the primary driver of this vehicle? _____
 - c. Do any individuals under the age of 21 have access to private passenger vehicle(s)? Yes No

Section 12 – Overnight care supplemental (Complete this section for each location. Please copy as necessary.)

Location #: _____

Location address: _____

1. Explain additional hours of operations:

2. Is the staff required to stay awake all night? Yes No
3. Is the facility kept locked and well lit? Yes No
4. Are only authorized persons allowed to come inside the facility and pick up children? Yes No
5. Are children under 5 years old allowed to sleep in the same room with older children? Yes No
6. Are children over 5 years old allowed to sleep in the same room with children of the opposite gender? Yes No
7. Are staff-to-child ratios maintained during the overnight hours? Yes No

Section 13 – Special needs supplemental

1. How many children are special needs? _____
2. Is someone on your staff trained to care for these children? Yes No
3. Is physical therapy provided? Yes No
4. Is an aide assigned to accompany the child? Yes No
5. Please describe the disabilities and special arrangements to care for these children:

Fair Credit Report Act Notice: Personal information about you, including information from a credit or other investigative report, may be collected from persons other than you in connection with this application for insurance and subsequent amendments and renewals. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization. Credit scoring information may be used to help determine either your eligibility for insurance or the premium you will be charged. We may use a third party in connection with the development of your score. You may have the right to review your personal information in our files and request correction of any inaccuracies. You may also have the right to request in writing that we consider extraordinary life circumstances in connection with the development of your credit score. These rights may be limited in some states. Please contact your agent or broker to learn how these rights may apply in your state or for instructions on how to submit a request to us for a more detailed description of your rights and our practices regarding personal information.

Fraud Warning: Any person who knowingly and with intent to defraud any Insurance Company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. (Not applicable in AL, AR, CO, DC, FL, KS, KY, LA, MD, ME, MN, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, VT, WA, and WV) (Insurance benefits may also be denied in LA, ME, TN, and VA.)

STATE FRAUD STATEMENTS**Applicable in AL, AR, DC, LA, MD, NM, RI and WV**

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in Maryland only.

Applicable in CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in Florida only.

Applicable in KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an

application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in New York only.

Applicable in ME, TN, VA and WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in Maine only.

Applicable in MN

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in VT

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization - I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which would materially affect this insurance has been withheld.

NOTE: Coverage cannot be bound until the Company approves your completed application. The Company's receipt of premium does not bind coverage until a written quote has been issued. Before electronically signing this document, verify your information is correct. Electronically signing will disable further editing of your application.

Applicant's signature: _____ Date: _____

Agent's signature: _____ Date: _____

(Florida only) Agent license number: _____

Questions? 800 926-6771

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