



APPLICATION - DAY CARE

BUSINESS INFORMATION

1. Named Insured _____
2. Mailing Address _____
Street City County State ZIP Code
3. Location of premises: Same as mailing address
 Other _____
4. Telephone (____) _____ Fax (____) _____
5. Contract person/phone #: Inspection _____
Accounting/Records _____
6. Business type: Individual Partnership Corporation LLC Other _____
7. Operating as: For Profit Nonprofit Other _____
8. Interest of Named Insured in premises: Owner General Lessee Tenant Other _____
9. Part occupied by Named Insured: Entire Portion(____%) Other (Lessor's Risk Only)
10. Date business established _____ Years of experience _____

DESIRED TERMS AND CONDITIONS

1. Coverage desired: General liability Professional liability
2. Limit of Liability Desired: \$100,000/\$300,000 \$300,000/\$600,000 \$500,000/\$1,000,000
 \$1,000,000/\$2,000,000 Other _____
3. Physical/Sexual Abuse: \$25,000/\$50,000 \$50,000/\$100,000 \$100,000/\$300,000

Note: Standard coverage includes the following:

Damage to Premises Rented to You \$100,000
 Personal and Advertising Injury Same as Occurrence Limit

4. Medical Payments: \$1,000
5. Effective Date Desired _____ Term Desired _____

TYPE OF FIRM

1. Type of firm: Drop-in Care All Ages Full-Time Care/No Infants - **Comm'l**
 Full-Time Care/All Ages - **Comm'l** Full-Time Care/No Infants - **In Home**
 Full-Time Care/All Ages - **In Home** Full-Time Care/Preschool - **Comm'l**
 Full-Time Care/ Infants - **Comm'l** Full-Time Care/Preschool - **In Home**
 Full-Time Care/Infants - **In Home** Full-Time Care/Sick Care
 Part-Time Care/Latch Key Programs

Description of operations. _____

OPERATIONS

1. Is facility licensed? Yes No
 If yes, indicate maximum number of children permitted by license in each age group:
 0 - 6 months _____
 6 months to 2 years _____
 2 years to 5 years _____
 Over 5 years _____
2. Has license ever been revoked or suspended? Yes No
3. Have any citations or warnings been issued? Yes No
 If yes to either of the above questions, describe. _____

4. Are children accepted with: Physical or emotional handicaps? Yes No
 Chronic illnesses? Yes No
 If yes, indicate procedures/staff/equipment in place to handle. _____

5. Hours children are on premises: _____ A.M. to _____ P.M.
6. Average daily attendance:
- | Age | # of Children | # of Teachers |
|----------------|---------------|---------------|
| 1 to 6 months | _____ | _____ |
| 6 to 24 months | _____ | _____ |
| 2 to 5 years | _____ | _____ |
| 5 years + | _____ | _____ |
7. Do you provide temporary "drop-in" care? Yes No

PREMISES

1. How often are premises inspected? _____ By Whom? _____
 Date of last inspection _____
2. What floors, other than ground level, are open to children? (e.g. basement) _____
 For what use _____
3. Condition of:
- | | | | | |
|--------------------|-------------------------------|-------------------------------|-------------------------------|---------------------------------------|
| Stairways | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> No Stairway |
| Stairway carpeting | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Not Carpeted |
| Is stairwell lit? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
- What are safety procedures in event of fire? _____

5. What safety equipment is on premises? Smoke Detectors Sprinklers Fire Extinguishers
 Other _____
6. a. Is the play area fully enclosed by a fence? Yes No
 b. Are there any trampolines? Yes No
 c. Are there any swimming pools or swimming facilities on the premises? Yes No
 d. Is any equipment on hard surfaces (such as concrete or asphalt)? Yes No
 e. List and describe all play equipment. _____

EMPLOYEE PROCEDURES & STAFFING

1. Number of attendants on duty at all times _____
Attach a full description of education, background, qualifications of each attendant.
- | | | | |
|--|---------------------|--------------------------|--------------------------|
| | | Yes | No |
| 2. Are the following checked on employees? | References | <input type="checkbox"/> | <input type="checkbox"/> |
| | Previous employers | <input type="checkbox"/> | <input type="checkbox"/> |
| | Criminal background | <input type="checkbox"/> | <input type="checkbox"/> |
3. Are copies of background checks kept on file? Yes No
4. Is staff trained in First Aid? Yes No
 Describe training. _____

RISK MANAGEMENT

1. What procedures exist for:
 a. Accidents, medical treatment, notification to parents _____
 b. Dispensing of prescribed medications _____
 c. Illness _____
- | | | | |
|--|--|------------|-----------|
| | | Yes | No |
|--|--|------------|-----------|
2. Are there written procedures/guidelines regarding discipline?
 Are they communicated to the parents?
3. Are any field trips or activities conducted away from premises?
 If yes, fully describe, including the estimated number of trips and/or activities.

 Are parents required to sign "permission" forms for each field trip?
4. Are any special instructions such as dance, tumbling, swimming, horseback riding, etc. provided?
 If yes, fully describe. _____

5. Are all incidents reported to your insurer?
 Number in past 12 months _____
 Describe procedures. _____

PREVIOUS EXPERIENCE

1. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of their professional activities? Yes No
 If yes, explain. _____

2. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**
 Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years?
 Yes No *If yes, give name of company, date and reason.*

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS					
Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

3. Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years. *Attach separate sheet if necessary.*

Dates (Month/Year)	Allegations	Amount	Paid	Reserve
			<input type="checkbox"/>	
			<input type="checkbox"/>	
			<input type="checkbox"/>	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant Title Date

Signature of Producing Agent Date

Agent Name and Address