



Endorsed by the National Association  
of Child Care Professionals

This application must be completed in its entirety before being accepted for submission. No coverage is bound or afforded by this application.

**General Information — APPLIES TO ALL LOCATIONS**

1. Proposed effective date: \_\_\_\_\_ Liability occurrence limits:  \$500,000  \$1,000,000  
Sexual abuse limits:  \$500,000/1,000,000  \$1,000,000/\$1,000,000
2. Named Insured (as to appear on policy): \_\_\_\_\_
3. Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
4. a. Business type:  Individual  Corporation  Partnership  Other: \_\_\_\_\_ b.  Profit  Nonprofit  
c.  Commercial Child Care no camp  Commercial Child Care with camp  Montessori  Nursery School  
 Head Start  Private School  Other: \_\_\_\_\_  
d. Federal ID No. \_\_\_\_\_ e. Are you a member of:  NAEYC  NCCA  NACCP
5. List all accreditations and attach copies of certificates: \_\_\_\_\_
6. Number of years applicant has been in this business: \_\_\_\_\_
7. Person to contact for inspection: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

**Employment Practices — APPLIES TO ALL LOCATIONS**

8. Are employees (paid & volunteer) required to complete an employment application?  Yes  No If no, explain: \_\_\_\_\_
9. Are criminal investigations conducted on all employees (paid & volunteer) before hiring?  Yes  No  
Explain how investigated: \_\_\_\_\_
10. Does your staff (paid and volunteer) employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offenses?  Yes  No
11. Do you discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if a child reports someone molested him/her?  Yes  No
12. Do you have a crisis management plan for dealing with participants, employees, children, parents, authorities, and media?  Yes  No
13. a. Have you had an incident which resulted in an allegation of sexual abuse?  Yes  No If yes, please describe details in Remarks Section including any resulting claims.  
b. Do you have guidelines that prohibit the use of corporal punishment?  Yes  No

**Facility — LOCATION 1** (Complete 1 additional location supplement per location.)

14. Do you operate more than one location?  Yes  No If yes, explain if not submitted to us: \_\_\_\_\_
15. How long has applicant operated at this location? \_\_\_\_\_
16. Location address, if different than mailing address: \_\_\_\_\_  
\_\_\_\_\_
17. Is the facility licensed by the State?  Yes (attach copy)  No If no, explain in Remarks Section.
18. Has the license ever been revoked?  Yes  No If yes, explain: \_\_\_\_\_
19. Hours of operation: From \_\_\_\_\_ to \_\_\_\_\_ Number of days per week: \_\_\_\_\_ Number of months per year \_\_\_\_\_
20. Do any children stay overnight?  Yes  No If yes, explain: \_\_\_\_\_
21. Child care facility located at:  Private home  Church  Apartment  YMCA  Commercial Bldg.  Other: \_\_\_\_\_
22. List other occupancies in the same building: \_\_\_\_\_
23. List adjacent businesses: \_\_\_\_\_
24. Additional Insured required? Name, address, relationship: \_\_\_\_\_  
\_\_\_\_\_

## Personnel — LOCATION 1

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25. Name of Executive Director/Manager: \_\_\_\_\_  
Number of years in child care: \_\_\_\_\_ Specialized training or education: \_\_\_\_\_
26. Number of teachers with degree: \_\_\_\_\_ Number of teachers without degree: \_\_\_\_\_
27. Number of Aides: \_\_\_\_\_ Number of Volunteers: \_\_\_\_\_ Number of Nurses: \_\_\_\_\_ Number of EMTs: \_\_\_\_\_
28. Number of Kitchen Staff: \_\_\_\_\_ Number of Janitorial Staff: \_\_\_\_\_ Other: \_\_\_\_\_
29. Total number of employees: \_\_\_\_\_ Any employees under 18 years of age?  Yes  No If yes, list position and how they are supervised: \_\_\_\_\_
30. Is there always someone trained in CPR and first aid on the premises?  Yes  No

## Enrollment — LOCATION 1

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31. Licensed Capacity: \_\_\_\_\_ Current Enrollment: \_\_\_\_\_ Avg. Number of Children per day: \_\_\_\_\_
32. Based on the maximum number of children enrolled on your busiest day, what is your actual breakdown of total staff to total number of children by age group (excluding director)?
- |                        |                    |                    |
|------------------------|--------------------|--------------------|
| Infants, ages 0-1      | _____ # Staff      | _____ # Children   |
| Toddlers, ages 1-2     | _____ # Staff      | _____ # Children   |
| Toddlers, ages 2-3     | _____ # Staff      | _____ # Children   |
| Preschoolers, ages 3-5 | _____ # Staff      | _____ # Children   |
| School age children    | _____ # Staff      | _____ # Children   |
|                        | _____ <b>Total</b> | _____ <b>Total</b> |
33. Are "special needs" children cared for?  Yes  No If yes, how many? \_\_\_\_\_
34. Describe the disabilities and special arrangements made to care for these children: \_\_\_\_\_  
\_\_\_\_\_

## Play Facilities — LOCATION 1

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35. Does the facility have its own play area?  Yes  No If no, give name of facility used: \_\_\_\_\_
36. Is play area fenced?  Yes  No Describe all playground equipment including the maximum height of the equipment: \_\_\_\_\_  
\_\_\_\_\_
37. Describe surface under playground equipment: \_\_\_\_\_ Depth of surface: \_\_\_\_\_
38. Do you utilize swimming facilities?  Yes  No If yes, complete the Swimming Pool Supplement.

## Operations — LOCATION 1

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39. Are precautions taken to prevent children from accessing cooking areas, stoves, microwave ovens, etc.?  Yes  No
40. Are precautions taken to prevent children being released to unauthorized persons?  Yes  No
41. Are procedures in place for dispensing medicine?  Yes  No
42. Are there any pets at this location?  Yes  No If yes, describe the pet, including size: \_\_\_\_\_
43. Are special classes provided?  Yes  No If yes, explain in remarks section. If special classes are taught by an independent contractor on your premises, do you require them to provide proof of liability coverage?  Yes  No

## Special Events — LOCATION 1

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44. Number of field trips conducted each year? \_\_\_\_\_ Are release forms obtained?  Yes  No
45. Describe each trip: \_\_\_\_\_
46. a. Describe any special events sponsored by the center: \_\_\_\_\_
- b. Do you rent facility to others?  Yes  No If so to whom? \_\_\_\_\_  
Do you obtain Certificates of Insurance?  Yes  No

**Transportation — LOCATION 1**

- 47. Does the facility provide transportation to and from the center?  Yes  No
- 48. Does the facility provide transportation for field trips?  Yes  No If no, how is it provided? \_\_\_\_\_
- 49. Are all drivers at least 21 years of age?  Yes  No Do you obtain MVRs on all drivers?  Yes  No
- 50. Do all drivers have a CDL license in accordance with state regulations?  Yes  No
- 51. If vehicles are hired for field trips, are they hired with a driver?  Yes  No
- 52. Do employees/volunteers transport children in their own vehicles?  Yes  No If yes, how often: \_\_\_\_\_
- 53. Are Certificates of Insurance required showing liability of at least \$300,000?  Yes  No
- 54. Total number of owned vehicles: \_\_\_\_\_ Total number of hired vehicles: \_\_\_\_\_ Annual cost of hire: \_\_\_\_\_
- 55. Is there a vehicle maintenance program in place?  Yes  No Do you obtain MVR verification?  Yes  No

Vehicle Information:

#1) Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Vin# \_\_\_\_\_  
 Original Cost New \_\_\_\_\_ Loss payee: \_\_\_\_\_

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#2) Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Vin# \_\_\_\_\_  
 Original Cost New \_\_\_\_\_ Loss payee: \_\_\_\_\_

**Property**

Loc # _____ Bldg # _____ Building Value \$ _____ Personal Property Value \$ _____ Co-insurance % _____ Deductible: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 Business income limit \$ _____ Year built _____ Total area _____ # of stories _____ Construction of building: <input type="checkbox"/> Frame <input type="checkbox"/> Block <input type="checkbox"/> Brick <input type="checkbox"/> Metal Year of building improvements: Wiring _____ Roofing _____ Plumbing _____ Heating _____ <input type="checkbox"/> Mortgagee <input type="checkbox"/> Loss payee: _____ _____ _____	Loc # _____ Bldg # _____ Building Value \$ _____ Personal Property Value \$ _____ Co-insurance % _____ Deductible <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 Business income limit \$ _____ Year built _____ Total area _____ # of stories _____ Construction of building: <input type="checkbox"/> Frame <input type="checkbox"/> Block <input type="checkbox"/> Brick <input type="checkbox"/> Metal Year of building improvements: Wiring _____ Roofing _____ Plumbing _____ Heating _____ <input type="checkbox"/> Mortgagee <input type="checkbox"/> Loss payee: _____ _____ _____
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**Inland Marine**

Computer hardware limit \$ \_\_\_\_\_ Laptop limit \$ \_\_\_\_\_ Software limit \$ \_\_\_\_\_  
 Transit limit \$ \_\_\_\_\_ Extra Expense \$ \_\_\_\_\_ Co-Insurance % \_\_\_\_\_  
 Deductible:  \$500  \$1,000

**Crime**

Employee dishonesty limit \$ \_\_\_\_\_  
 Money & securities on premises limit \$ \_\_\_\_\_  
 Money & securities off premises limit \$ \_\_\_\_\_  
 Deductible:  \$500  \$1,000  
 Audit frequency?  Annual  Semi-annual  Quarterly  Other  
 Are bank accounts reconciled by someone not authorized to deposit or withdraw?  Yes  No  
 Is countersignature of checks required?  Yes  No  
 Will securities be subject to joint control of two or more responsible employees?  Yes  No  
 Are all officers and employees required to take annual vacations of at least five consecutive business days?  Yes  No

**Umbrella**

Limit \$ \_\_\_\_\_

**Prior Coverage — APPLIES TO ALL LOCATIONS**

55. Has any prior coverage been cancelled or non-renewed?  Yes  No If yes, explain: \_\_\_\_\_

Policy Type	Company	Effective Date	Limit	Total Premium
Accident Med.	_____	_____	_____	_____
General Liab.	_____	_____	_____	_____
Property	_____	_____	_____	_____
Auto	_____	_____	_____	_____
Workers Comp.	_____	_____	_____	_____
Other	_____	_____	_____	_____

**Loss History — APPLIES TO ALL LINES OF COVERAGES, ALL LOCATIONS**

Enter all claims or occurrences that may give rise to claims for the prior 5 years.  Check here if None  See attached Loss Summary

Date of Occurrence	Line	Type/Description of occurrence or claim	Date of Claim	Amount Paid	Amount Reserved	Claim Status
_____	_____	_____	_____	_____	_____	O C
_____	_____	_____	_____	_____	_____	O C
_____	_____	_____	_____	_____	_____	O C

Circle for Claim Status: O = Open C = Closed

**Remarks**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAIR CREDIT REPORT ACT NOTICE:** An investigative consumer report may be requested by the insurer to which this application is assigned as to the consumer's character, general reputation, personal characteristics, and mode of living. Subsequent consumer reports may be requested in connection with an update or renewal or extension of the insurance which this application is made. The applicant will be informed of the name and address of the consumer reporting agency that furnished the report.

Any person who knowingly and with intent to defraud any insurance company or other person files a 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Agency Name: \_\_\_\_\_ License# \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_