# EQUINE ASSISTED THERAPY SUPPLEMENT

Submit with Equine CGL Application

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>Program Administrator: Allen Financial Insurance Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Producer Name:</td>
<td>Direct 800-874-9191</td>
</tr>
<tr>
<td>Producer Email:</td>
<td>FAX 602-992-8327</td>
</tr>
<tr>
<td>Producer Phone:</td>
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</tbody>
</table>

Effective Date:        Expiration Date:        Quote Desired By:

Name of Applicant:

Mailing Address:

City, State, Zip:

☐ Individual    ☐ Partnership    ☐ LLC    ☐ Corporation    ☐ Not For Profit

Inspection Contact:        Email:

Telephone # (Required):        Website:

Social Security / Federal Tax ID:

Method of Payment:        Payments:        Type of Activities Offered (Check all that apply)

<table>
<thead>
<tr>
<th>Agency Bill</th>
<th>Direct Bill</th>
<th>☐ Annual</th>
<th>☐ Semi-Annual</th>
<th>☐ Quarterly</th>
<th>☐ Monthly (25%+9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Equine Assisted Psychotherapy</td>
<td>☐ Therapeutic Riding</td>
<td>☐ Equine Assisted Learning</td>
<td>☐ Hippo-therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Shows / Clinics</td>
<td>☐ Riding Instruction</td>
<td>☐ Boarding / Breeding</td>
<td>☐ Horse Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Horse Sales</td>
<td>☐ Hay / Sleigh Rides</td>
<td>☐ Pony Ride / Petting Zoo</td>
<td>☐ Playground</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Day or Overnight Camps</td>
<td>☐ Driving</td>
<td>☐ Swimming / Fishing</td>
<td>☐ Meal Preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Non-Related Equine Therapy</td>
<td>☐ Residential Group Home</td>
<td>☐ Vaulting</td>
<td>☐ Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Industry Affiliations & Accreditations (Check all that apply)

| ☐ PATH | ☐ EAGALA | ☐ NARHA |
| ☐ American Hippo Therapy Assn | ☐ ATRA | Equine Connection |
| ☐ American Counseling Assn | ☐ American Psychiatric Assn | ☐ OK Corral |
| ☐ AAMFT | ☐ IAMFC | ☐ Wounded Warrior Project |
| ☐ APBA | ☐ CSWA | ☐ Other |

Is Program Accredited?    ☐ Yes    ☐ No

How long has applicant been in this field?        Gross receipts?  $

Is this new business to your agency?        How long have you known applicant?

I/We understand and agree that any misstatement of warranty or fact on this application shall be considered a violation of coverage afforded under any policy issued on the basis of this application. The insured assigns as security for the total premium and/or fees payable any and all unearned premiums which may become payable. I/We agree to pay reasonable attorneys fees, costs and expenses necessarily incurred if suit or collection becomes necessary.

Applicant's signature:        Agent's signature:

Date:        Date:

Allen Financial Insurance Group / The Equestrian Group        Website: www.EQGroup.com

EQG-EAT-030918
## OPERATIONS OVERVIEW

### Additional Premises Operations

- Farming Operations
- Bed & Breakfast
- Day or Overnight Camps
- Swimming Pool
- Farm “Pick Your Own” sales
- RV Hookups / Campsites
- Special Events
- Home Day Care
- Retail Sales
- Kennels
- Pony Ride / Petting Zoo
- Retail Store
- Guided Trail Rides
- Other

**Does the Applicant operate any type of “At Risk” program defined as persons involved in the Center’s program as a result of and local, state, federal government or court mandated program including but not limited to criminal rehabilitation or community service sentencing.**

If Yes, provide details including copy of agreement with assigning agency.

### Number of employees

<table>
<thead>
<tr>
<th>Full time</th>
<th>Part time</th>
<th>Annual payroll</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$</td>
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</tbody>
</table>

**Does the Applicant carry Workmen’s Compensation insurance?**

- Yes
- No

**Licensed by *****

Attach copy of state or governmental licenses

If Yes, has your license ever been suspended or revoked? Yes  No

If Yes, include explanation.

**Is this program part of any school curriculum, recreational center or in any way associated with a city, county or state program?**

- Yes
- No

**Is there 24 hour supervision of facility?**

- Yes
- No

If No explain

**Does the Applicant use any unlicensed motorized vehicles i.e. Golf Carts, ATV, Scooters, etc?**

- Use of any vehicle is limited to Applicant and Employees only.

- Yes
- No

**Do you provide transportation to and from the facility?**

- Yes
- No

If YES Please explain

**Do you have a written and enforced Smoking Policy?**

Are “no smoking” signs posted in areas not designated for smoking?

- Yes
- No

**Does the Applicant have any exchange labor working for the Facility?**

- Yes
- No

If YES explain

Bodily Injury to any person arising out of and in the course of a person acting on the behalf of the named insured, whether through employment, voluntary or otherwise is not covered by general liability in this policy. Coverage for bodily injury to employees is provided for in accident medical coverage and workman’s compensation coverage.

Has any staff member had any history of violence or criminal behavior?

- Yes
- No

**Funding sources:**

- Check all that apply

- Client Fees
- Federal
- State
- County
- Donations
- Other

**Annual operating budget:** $  

**Does the entity have:**

- Yes
- No

- Budget Deficit
- Operational Reserves

If deficit please explain
### MANAGEMENT PRACTICES

1. Is the staff required to report to the administrator all incidences that may result in a claim?  
   - Yes  
   - No

2. Are written records of all incidences kept by the administrator?  
   - Yes  
   - No

3. Are all incidences reviewed?  
   - Yes  
   - No

4. Do you have a formal written safety program in place?  
   - Yes  
   - No

5. Does the facility have a written emergency evacuation plan? If Yes, attach a copy.  
   - Yes  
   - No

6. Is there always someone trained in CPR and first aid on the premises?  
   - Yes  
   - No

7. Do you have AED(s)?  
   - Yes  
   - No  
   Are staff members trained to use?  
   - Yes  
   - No

8. What type of method do you use for de-escalation?  
   - Yes  
   - No

9. Do you have any security provided for protection of your clients/residents?  
   - Yes  
   - No  
   - Guards  
   - Video Cameras  
   - Other

10. Do you have sign in/sign out procedures for:  
    - Staff  
    - Clients / Residents  
    - Visitors / Public

---

### Locations to be Insured

(Include County and Zip Code)

<table>
<thead>
<tr>
<th>Loc. #</th>
<th>Sec.I</th>
<th>Sec.II</th>
<th># of Acres</th>
<th>Check if NO Buildings</th>
<th>Insured’s Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Owner Occupant</td>
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<tr>
<td></td>
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<td></td>
<td></td>
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<td>Lessee Lessor</td>
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</table>

### PRIOR CARRIER INFORMATION

<table>
<thead>
<tr>
<th>Line</th>
<th>Category</th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
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<tbody>
<tr>
<td></td>
<td>Carrier</td>
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<tr>
<td></td>
<td>Policy No.</td>
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<td></td>
<td>Policy Type</td>
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<td></td>
<td>BI/CSL</td>
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<tr>
<td></td>
<td>Total Premium</td>
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</tr>
</tbody>
</table>

### LOSS HISTORY

Enter all claims or occurrences that may give rise to claims for 5 years

<table>
<thead>
<tr>
<th>Date of Occurrence</th>
<th>Line</th>
<th>Type/Description of Occurrence or Claim</th>
<th>Date of Claim</th>
<th>Amount Paid</th>
<th>Amount Reserved</th>
<th>Claim Status</th>
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</table>

<table>
<thead>
<tr>
<th>Has any policy been cancelled?</th>
<th>Yes</th>
<th>No</th>
<th>Non-renewed?</th>
<th>Yes</th>
<th>No</th>
<th>Declined?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever contributed to a claim or accident or found negligent in any past equine activity?</td>
<td>Yes</td>
<td>No</td>
<td>Explain yes answers:</td>
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</tbody>
</table>
## COMMERCIAL LIABILITY SECTION

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Limits of Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bodily Injury and Property Damage Liability</td>
<td>$1,000,000 Each &quot;Occurrence&quot; Limit</td>
</tr>
<tr>
<td></td>
<td>$3,000,000 General Aggregate Limit</td>
</tr>
<tr>
<td>Personal and Advertising Injury Liability</td>
<td>$1,000,000 Each &quot;Occurrence&quot; Limit</td>
</tr>
<tr>
<td></td>
<td>$3,000,000 General Aggregate Limit</td>
</tr>
<tr>
<td>Medical Payments</td>
<td>$5,000 Any One Person Limit</td>
</tr>
<tr>
<td></td>
<td>$25,000 Each &quot;Occurrence&quot; Limit</td>
</tr>
<tr>
<td>Damage to Property of Others</td>
<td>$100,000</td>
</tr>
<tr>
<td>Excess Liability Limit</td>
<td>$</td>
</tr>
</tbody>
</table>

**Commercial Liability?**  ☐ Yes ☐ No

If Other than Equine Therapy, complete commercial equine liability supplement

**Human Services Professional Liability?**  ☐ Yes ☐ No

Complete professional liability section

**Property / Farm Coverage?**  ☐ Yes ☐ No

Complete ACORD / Farm application

**Automobile Coverage?**  ☐ Yes ☐ No

Submit ACORD automobile application

**Excess Liability Coverage?**  ☐ Yes ☐ No

Submit ACORD application

### ADDITIONAL INTERESTS

<table>
<thead>
<tr>
<th>Affiliated or subsidiary companies to be insured</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Insureds</td>
<td>Interest</td>
</tr>
<tr>
<td>Sec.I Sec.II</td>
<td></td>
</tr>
</tbody>
</table>

| Additional Insureds                             | Interest     |
| Sec.I Sec.II                                    |              |
### EQUINE ASSISTED THERAPY

**Does the Program operate during all months of the year?** □ Yes □ No

If seasonal indicate operational dates:

<table>
<thead>
<tr>
<th>Percentage of equine therapy work:</th>
<th>Mounted: ___ %</th>
<th>Unmounted: ___ %</th>
</tr>
</thead>
</table>

**Estimated total number of assisted therapy sessions per year (Group & Individual): _____**

**Average number of individual participants per session: _____**

\[
\text{Avg # of Participants per Session} \times \text{Total # of Annual Session Days} = \text{Total Annual Participant Days}
\]

**Total number of annual “Client Participant Days”: _____**

**Minimum age of client accepted into program _____**

**Average number of horses use per session _____**

**Maximum number per session _____**

### Facilities used for equine therapy Operations (Check all that apply)

- □ Indoor Arena
- □ Outdoor Arena
- □ Trails
- □ Other

**Do you attend off premises shows or demonstrations with client participants?** □ Yes □ No

If Yes, please describe:

**Do you have emergency procedures?** □ Yes □ No

Please attach copy of written procedures

**Do you provide transportation to clients?** □ Yes □ No

If Yes, please describe:

**Please describe the general scope of disabilities your Program specializes in:**

**Do you have a training program for volunteers and trainees?** □ Yes □ No

Please attach copy of training guidelines

**Do you perform background checks on all personnel?** □ Yes □ No

**Has any staff member had any history of violence or criminal behavior?** □ Yes □ No

### THERAPEUTIC RIDING

**If Yes, Do you use side walkers?** □ Yes □ No

**What is the ratio between staff and participant? Sidewalkers to rider = _____**

**Do you follow NARHA standards & guidelines** □ Yes □ No

**Do you fasten a child to any part of the saddle?** □ Yes □ No

**Are safety helmets mandatory?** □ Yes □ No

**Minimum age of riders** □ Yes □ No
Are liability waivers signed by all parents / guardians?  

- Yes  
- No

Therapeutic riding operations include:  
- Hippotherapy  
- Equitherapy

If Yes what type of professional(s) are providing these services?  

- Physical Therapist  
- Occupational Therapist  
- Speech Therapist  
- Other

### EMPLOYEE / VOLUNTEER EXPERIENCE

List all personnel including instructors, employees, therapists, volunteers and trainees

<table>
<thead>
<tr>
<th>Names of W2 employees / volunteers to be insured under this policy.</th>
<th>Occupation * License or Certification</th>
<th>Owner, Partner Or Officer ?</th>
<th>W2 Employee or Volunteer ?</th>
</tr>
</thead>
<tbody>
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</table>

*For any Paraprofessionals (unlicensed or uncertified please indicate job title and duties

### SCHEDULE OF HORSES - TRAINING / EXPERIENCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Breed / Age</th>
<th># of Years in program</th>
<th>Experience &amp; Training</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Has any horse ever shown any aggressive behavior?  

- Yes  
- No

Describe criteria used in horse selection:
Are there any non-owned program horses? □ Yes □ No
If Yes, please describe:

Section 2

PROFESSIONAL LIABILITY SECTION

Completed this section only if Behavioral Services Professional Liability Coverage is needed
The coverage includes all equine and non-equine behavioral therapy services

HIRING PRACTICES

1. a. Are formal written procedures in place for staff hiring? □ Yes □ No
   b. Do you require your staff to complete an employment application? □ Yes □ No
   c. Do you conduct a personal interview for each prospective staff member? □ Yes □ No
   d. Do you verify employment related references? □ Yes □ No
   e. Do you verify licenses and other credentials? □ Yes □ No
   f. Do you obtain criminal background checks, which check at least 10 years of data from
      50 states, on ALL staff before start date? □ Yes □ No
   g. Do you require drug tests on all staff members, including drivers?
      □ Before Hiring □ After Hiring □ Random Testing □ Yes □ No
   h. What actions do you take if any of these reports are unfavorable?: □ Yes □ No

2. Do you share written job descriptions with all staff members? □ Yes □ No

3. Name of executive director/manager:

4. Is there formal staff training? □ Yes □ No

5. Are files maintained to protect the confidentiality of clients? □ Yes □ No

6. Do you perform any consulting work? □ Yes □ No
   If Yes explain:

7. Are clients referred to specialists when appropriate? □ Yes □ No

8. Do you have volunteer workers? □ Yes □ No
   If Yes, complete the section below:
   Is a complete background check required for all volunteers the same as for employees? □ Yes □ No
   If No explain:

   Are any volunteers working-off court-mandated community service? □ Yes □ No
   If Yes explain:

9. If contracted professionals are used, does the Insured require them to sign a hold
   harmless or indemnification agreement? □ Yes □ No
   If Yes, Are Certificates of Insurance required and kept in file for those contracted
   professionals? □ Yes □ No
   If Yes, what are the minimum limits of liability required? $ □ Yes □ No

10. Are medications dispensed? □ Yes □ No
    If Yes, answer the following questions:
    a. Where are the medications stored? □ Yes □ No
    b. Who has the authority to dispense medications? □ Yes □ No
    c. Can over-the-counter medicines be dispensed without written permission from a
       doctor? □ Yes □ No
    d. Are written records kept as to the time, type of medication, amount of dosage and who
       dispensed the medications? □ Yes □ No

11. What is the staff turnover percentage for professional staff? □ Yes □ No

12. Do you have any employed or contracted Psychiatrists or Physicians (other MD’s)? □ Yes □ No
    If Yes, answer the following questions:
a. Are any Psychiatrists a member of American Academy of Child & Adolescent Psychiatry (AACAP) □ Yes □ No

b. Does any Psychiatrist perform any clinical or pharmaceutical research on clients? □ Yes □ No

If Yes explain:

c. Does the Psychiatrist get informed consent prior to prescribing medications? □ Yes □ No

d. Complete table below:

<table>
<thead>
<tr>
<th>NAME</th>
<th>Dr.</th>
<th>Dr.</th>
<th>Dr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
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<tr>
<td>Board Certified or Eligible</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Years in Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>License Number</td>
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<tr>
<td>Hours p/wk for Insured</td>
<td></td>
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<tr>
<td>Employed or Contracted?</td>
<td>□ Employ □ Contract</td>
<td>□ Employ □ Contract</td>
<td>□ Employ □ Contract</td>
</tr>
<tr>
<td>Does physician carry own Malpractice insurance? ****</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>If yes, does coverage include acts while working for this agency?</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>If yes, does coverage include Contingent Coverage for this agency?</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Any claims in past 5 years?</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

****Provide Certificate of Medical Malpractice for each Psychiatrist or Physician

ABUSE & MOLESTATION

1. Does your staff employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses? □ Yes □ No

2. Does Insured run criminal background checks for employees? Yes No For volunteers? □ Yes □ No

3. Do you have written procedure for dealing with physical and sexual abuse? Yes No If Yes, attach a copy. □ Yes □ No

4. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients both on and off-premises? □ Yes □ No

5. Are procedures in place to avoid one-on-one situations so that more than one employee/volunteer is present at all times when a child is in your care? □ Yes □ No

6. is there documented formal staff training on child/sexual abuse, including how to recognize the signs and how to report a known or suspected incident? □ Yes □ No

7. Indicate annual number of clients in each age range for all programs/services: □ Yes □ No

- 0 to 8 □ 9 to 18 □ 18 and Over

<table>
<thead>
<tr>
<th>POSITION</th>
<th>EMPLOYEE</th>
<th>VOLUNTEER</th>
<th>CONTRACTOR</th>
<th>INTERN</th>
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<tbody>
<tr>
<td>Administrator</td>
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<tr>
<td>Child Care Worker</td>
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<tr>
<td>Clergy</td>
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<tr>
<td>Clerical/Office Staff</td>
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<tr>
<td>Counselor (other)</td>
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<tr>
<td>Home Health Aide</td>
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<tr>
<td>Nurse Practitioner</td>
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<tr>
<td>Nurse—LPN</td>
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<tr>
<td>Nurse—RN</td>
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<tr>
<td>Nutritionist</td>
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<tr>
<td>Physician</td>
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<tr>
<td>Psychiatrist</td>
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<tr>
<td>Psychologist</td>
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<tr>
<td>Resident Manager</td>
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<tr>
<td>Social Worker – Bachelors (BSW)</td>
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<tr>
<td>Social Worker – Masters (MSW)</td>
<td>Teacher/Tutor/Aid</td>
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<tr>
<td>Therapist–Occupational</td>
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<td>Therapist–Physical</td>
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<td>Therapist–Speech/Hearing</td>
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<td>Other Positions (specify):</td>
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</table>

**RELEASES / WAIVERS / PROFESSIONAL LIABILITY**

Submit the following if application to your operation

- [ ] Medical release form being used
- [ ] Client Hold Harmless / Liability Release
- [ ] Volunteer Hold Harmless / Liability Release
- [ ] Professional liability insurance certificate held by Therapists
- [ ] Employee / Volunteer handbook, rules, guidelines, safety training

Notes & Comments: