THE EQUESTRIAN GROUP

A division of Allen Financial Insurance Group

EQUINE ASSISTED THERAPY SUPPLEMENT

Submit with Equine CGL Application

Date:

Renewal of #

Agency Name:	Program Administrator: Allen Financial Insurance Group	Direct 800-874-9191 FAX 602-992-8327
Producer Name: Producer Email: Producer Phone:	☑ Commercial General Liability ☐ Excess Liability ☐ Workmans Compensation	

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: ☐ Agency Bill ☐ Direct Bill

Payments: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (25%+9)

Type of Activities Offered (Check all that apply)

☐ Equine Assisted Psychotherapy	☐ Therapeutic Riding	☐ Equine Assisted Learning	☐ Hippo-therapy
☐ Shows / Clinics	☐ Riding Instruction	☐ Boarding / Breeding	☐ Horse Training
☐ Horse Sales	☐ Hay / Sleigh Rides	☐ Pony Ride / Petting Zoo	☐ Playground
☐ Day or Overnight Camps	☐ Driving	☐ Swimming / Fishing	☐ Meal Preparation
☐ Non-Related Equine Therapy	☐ Residential Group Home	☐ Vaulting	☐ Other

Industry Affiliations & Accreditations (Check all that apply)

Is Program Accredited? ☐ Yes ☐ No

☐ 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	☐

How long has applicant been in this field?	Gross receipts? $
Is this new business to your agency? Yes ◯ No ◯	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:	

OPERATIONS OVERVIEW

Additional Premises Operations (Check all that apply)

☐ Farming Operations	☐ Farm "Pick Your Own" sales	☐ Retail Sales	☐ Home Day Care
☐ Bed & Breakfast	☐ RV Hookups / Campsites	☐ Kennels	☐ Retail Store
☐ Day or Overnight Camps	☐ Special Events	☐ Pony Ride / Petting Zoo	☐ Guided Trail Rides
☐ Swimming Pool			☐ 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? ☐ Yes ☐ No

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

Number of employees: Full time _____ Part time _____ Annual payroll $ _____

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? If YES Please explain	☐ Yes ☐ No
Is there 24 hour supervision of facility ☐ Yes ☐ No If No explain	☐ Yes ☐ No
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? If YES Please explain	☐ Yes ☐ No
Do you have a written and enforced Smoking Policy? Are "no smoking" signs posted in areas not designated for smoking?	☐ Yes ☐ No ☐ Yes ☐ No
Does the Applicant have any exchange labor working for the Facility? 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 ☐ Yes ☐ No

Funding sources: Check all that apply

☐ Client Fees ☐ Federal ☐ State ☐ County ☐ Donations ☐ Other

Annual operating budget: $

Does the entity have: ☐ 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?	
	How often is the staff recertified?	
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:	☐ Yes ☐ No
	☐ Staff ☐ Clients / Residents ☐ Visitors / Public	

Loc. #	Sec.I	Sec.II	Locations to be Insured (Include **County** and **Zip Code**)	# of Acres	Check if **NO** Buildings	Insured's Interest		
						Owner Occupant	Lessee	Lessor
	☐	☐			☐	☐	☐	☐
	☐	☐			☐	☐	☐	☐
	☐	☐			☐	☐	☐	☐
	☐	☐			☐	☐	☐	☐
	☐	☐			☐	☐	☐	☐

PRIOR CARRIER INFORMATION				
Line	Category	Year	Year	Year
LIABILITY	Carrier	•		
	Policy No.			
	Policy Type			
	BI/CSL			
	Total Premium	•		

LOSS HISTORY ☐ Check here if none

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

Date of Occurrence	Line	Type/Description of Occurrence or Claim	Date of Claim	Amount Paid	Amount Reserved	Claim Status
						☐ Open ☐ Closed
						☐ Open ☐ Closed
						☐ Open ☐ Closed

Has any policy been cancelled? ☐ Yes ☐ No Non-renewed? ☐ Yes ☐ No Declined? ☐ Yes ☐ No

Have you ever contributed to a claim or accident or found negligent in any past equine activity? ☐ Yes ☐ No
Explain yes answers:

COMMERCIAL LIABILITY SECTION

Coverage	Limits of Liability
Bodily Injury and Property Damage Liability	$ 1,000,000 Each "Occurrence" Limit $ 2,000,000 General Aggregate Limit
Personal and Advertising Injury Liability	$ 1,000,000 Each "Occurrence" Limit $ 2,000,000 General Aggregate Limit
Medical Payments	$ 5,000 Any One Person Limit $ 25,000 Each "Occurrence" Limit
Damage to Property of Others	$ 100,000
Excess Liability Limit	$
Equine Commercial Liability? ■ Yes ☐ No	Other Equine Services? ☐ Yes ☐ No Submit for Company approval
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	Do you carry Directors & Officers E&O Coverage ○ Yes ○ No Do you want to add coverage to this quote? ○ Yes ○ No

ADDITIONAL INTERESTS	Affiliated or subsidiary companies to be insured	Relationship		
	Additional Insureds	Interest	Sec.I	Sec.II
	Additional Insureds	Interest	Sec.I	Sec.II

EQUINE ASSISTED THERAPY

Duplicate this page for each therapeutic location

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

If seasonal indicate operational dates:

Percentage of equine therapy work: Mounted: _____ % Unmounted: _____ %

Estimated total number of equine therapy "Client Days" annually. Example: 5 individuals in one session for one day would equal 5 client days. Total number of annual "Client Participant Days" = _____

Average number of program days per year: _____

Average number of individual participants per session: _____

Avg # of Participants per Daily Group Session X Total # of Annual Session Days = Total Annual 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 PATH - 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

	Are liability waivers signed by all parents / guardians? ☐ Yes ☐ No Therapeutic riding operations include: Hippotherapy ☐ Equi-therapy ☐ 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

Names of W2 employees / volunteers to be insured under this policy.	Occupation * License or Certification	Owner, Partner Or Officer ?	W2 Employee or Volunteer ?

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

SCHEDULE OF HORSES - TRAINING / EXPERIENCE

Copy this page in necessary

Name	Breed / Age	# of Years in program	Experience & Training

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 <u>all equine and non-equine behavioral therapy services</u>

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
	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:	
	Number of years in this field: Number of years at this facility:	
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? If Yes, complete the section below:	☐ Yes ☐ No
	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? If Yes, attach a copy of the standard 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? $	
10.	Are medications dispensed? If Yes, answer the following questions:	☐ Yes ☐ No
	a. Where are the medications stored?	
	b. Who has the authority to dispense medications?	

	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? %	
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:	

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

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

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: