



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:	<input type="checkbox"/> Commercial General Liability <input type="checkbox"/> Add Equine Professional Liability Option <input type="checkbox"/> Add Excess Liability	
Producer Email:		
Producer Phone:		
Effective Date:	Expiration Date:	Quote Desired By:

Name of Applicant:

Mailing Address:

City, State, Zip:

<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> LLC	<input type="checkbox"/> Corporation	<input type="checkbox"/> Not For Profit
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Inspection Contact:	Email:
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Telephone # (Required):	Website:
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Social Security / Federal Tax ID:

Method of Payment: <input type="checkbox"/> Agency Bill <input type="checkbox"/> Direct Bill	Payments: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (25%+9)
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Type of Activities Offered (Check all that apply)

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

Industry Affiliations & Accreditations (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> PATH | <input type="checkbox"/> EAGALA |
| <input type="checkbox"/> American Hippo Therapy Assn | <input type="checkbox"/> ATRA |
| <input type="checkbox"/> American Counseling Assn | <input type="checkbox"/> American Psychiatric Assn |
| <input type="checkbox"/> AAMFT | <input type="checkbox"/> IAMFC |
| <input type="checkbox"/> APBA | <input type="checkbox"/> CSWA |

Is Program Accredited? Yes No

- | |
|--|
| <input type="checkbox"/> NARHA |
| <input type="checkbox"/> Equine Connection |
| <input type="checkbox"/> OK Corral |
| <input type="checkbox"/> Wounded Warrior Project |
| <input type="checkbox"/> Other |

How long has applicant been in this field?	Gross receipts? \$
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Is this new business to your agency? Yes No	How long have you known applicant?
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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:
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Date:	Date:
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OPERATIONS OVERVIEW

Additional Premises Operations (Check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Farming Operations | <input type="checkbox"/> Farm "Pick Your Own" sales | <input type="checkbox"/> Retail Sales | <input type="checkbox"/> Home Day Care |
| <input type="checkbox"/> Bed & Breakfast | <input type="checkbox"/> RV Hookups / Campsites | <input type="checkbox"/> Kennels | <input type="checkbox"/> Retail Store |
| <input type="checkbox"/> Day or Overnight Camps | <input type="checkbox"/> Special Events | <input type="checkbox"/> Pony Ride / Petting Zoo | <input type="checkbox"/> Guided Trail Rides |
| <input type="checkbox"/> Swimming Pool | | | <input type="checkbox"/> 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? Yes No
 If YES Please explain

Is there 24 hour supervision of facility Yes No Yes No
 If No explain

Does the Applicant use any unlicensed motorized vehicles i.e. Golf Carts, ATV, Scooters, etc? Yes No
 Use of any vehicle is limited to Applicant and Employees only.

Do you provide transportation to and from the facility? Yes No
 If YES Please explain

Do you have a written and enforced Smoking Policy? Yes No
 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: 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are written records of all incidences kept by the administrator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are all incidences reviewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you have a formal written safety program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Does the facility have a written emergency evacuation plan? If Yes, attach a copy.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Is there always someone trained in CPR and first aid on the premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you have AED(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are staff members trained to use?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Guards <input type="checkbox"/> Video Cameras <input type="checkbox"/> Other	
10.	Do you have sign in/sign out procedures for:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Staff <input type="checkbox"/> Clients / Residents <input type="checkbox"/> 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
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR CARRIER INFORMATION

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

LOSS HISTORY

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

Check here if none

Date of Occurrence	Line	Type/Description of Occurrence or Claim	Date of Claim	Amount Paid	Amount Reserved	Claim Status	
						<input type="checkbox"/>	Open
						<input type="checkbox"/>	Closed
						<input type="checkbox"/>	Open
						<input type="checkbox"/>	Closed
						<input type="checkbox"/>	Open
						<input type="checkbox"/>	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
	\$ 3,000,000	General Aggregate Limit
Personal and Advertising Injury Liability	\$ 1,000,000	Each "Occurrence" Limit
	\$ 3,000,000	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Equine Professional Liability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Property / Farm Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Complete ACORD / Farm application	Automobile Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Submit ACORD automobile application	
Excess Liability Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Submit ACORD application		

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 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 all equine and non-equine behavioral therapy services

HIRING PRACTICES

1.	a. Are formal written procedures in place for staff hiring?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Do you require your staff to complete an employment application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Do you conduct a personal interview for each prospective staff member?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Do you verify employment related references?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you verify licenses and other credentials?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	g. Do you require drug tests on all staff members, including drivers? <input type="checkbox"/> Before Hiring <input type="checkbox"/> After Hiring <input type="checkbox"/> Random Testing	<input type="checkbox"/> Yes <input type="checkbox"/> No
	h. What actions do you take if any of these reports are unfavorable?:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you share written job descriptions with all staff members?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Are files maintained to protect the confidentiality of clients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do you perform any consulting work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes explain:	
7.	Are clients referred to specialists when appropriate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Do you have volunteer workers? If Yes, complete the section below:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is a complete background check required for all volunteers the same as for employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If No explain:	
	Are any volunteers working-off court-mandated community service?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Are Certificates of Insurance required and kept in file for those contracted professionals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, what are the minimum limits of liability required? \$	
10.	Are medications dispensed? If Yes, answer the following questions:	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Are written records kept as to the time, type of medication, amount of dosage and who dispensed the medications?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, answer the following questions:	
	a. Are any Psychiatrists a member of American Academy of Child & Adolescent Psychiatry (AACAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Does any Psychiatrist perform any clinical or pharmaceutical research on clients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes explain:	
	c. Does the Psychiatrist get informed consent prior to prescribing medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Complete table below:	

NAME	Dr.	Dr.	Dr.
Specialty			
Board Certified or Eligible	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Years in Practice			
License Number			
Hours p/wk for Insured			
Employed or Contracted?	<input type="checkbox"/> Employ <input type="checkbox"/> Contract	<input type="checkbox"/> Employ <input type="checkbox"/> Contract	<input type="checkbox"/> Employ <input type="checkbox"/> Contract
Does physician carry own Malpractice insurance? ****	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does coverage include acts while working for this agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does coverage include Contingent Coverage for this agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any claims in past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Does Insured run criminal background checks for employees? Yes No For volunteers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Do you have written procedure for dealing with physical and sexual abuse? Yes No If Yes, attach a copy.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you have a plan of supervision that monitors staff in day-to-day relationships with clients both on and off-premises?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Indicate annual number of clients in each age range for all programs/services:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> 0 to 8 <input type="checkbox"/> 9 to 18 <input type="checkbox"/> 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: