

*Capitol Insurance Companies
Through Amherst Insurance Agency*

Name: _____

Address: _____

Phone: _____ *Fax:*

Email address: _____

Number of Children: _____

Assistants if any _____

Hours: _____

Animals: _____



Capitol Indemnity Corporation
 Capitol Specialty Insurance Corporation
 Platte River Insurance Company

Amherst Insurance Agency Inc.
 Amherst Financial Services Agency
 20 Gatehouse Road, PO Box 48
 Amherst Massachusetts 01004-0048

CHILD DAY CARE QUESTIONNAIRE

Please answer all questions fully. Submit this Questionnaire with a **completed** ACORD Commercial Insurance Applicant Information Section and prior carrier loss runs.

Named Insured: _____

Do all professionals, and the business, have current licenses where required by statute? Yes No
 If the business maintains a web site, state the address: _____

LICENSING INFORMATION

1. Licensing Agency: _____
2. Number of years licensed: _____ Number of children on license: _____
 (Please attach copy of license) Note: Premium based on licensed capacity
3. Indicate maximum number of children permitted by license in each group:
 0 - 6 Months _____ 6 - 12 months _____ 12 - 18 months _____
 18 mos. - 2 years _____ 2 years - 5 years _____ Over 5 years _____
4. Does your child to staff ratio meet your licensing requirement? Yes No
 If no, please explain: _____
5. Has your license ever been revoked or suspended? Yes No
 If yes, please explain: _____
6. Do you accept children with physical, mental or emotional handicaps? Yes No
7. Do you accept children with chronic illness? Yes No
 If yes, describe any procedures or staff employed to supervise such children:

BUSINESS CHARACTERISTICS

1. Type of business: (check all that apply)

<input type="checkbox"/> Commercial	<input type="checkbox"/> Scheduled attendance	<input type="checkbox"/> Full time care	<input type="checkbox"/> All ages	<input type="checkbox"/> Sick care
<input type="checkbox"/> In home	<input type="checkbox"/> Drop in care	<input type="checkbox"/> Part time care / Latch Key programs	<input type="checkbox"/> No infants	
			<input type="checkbox"/> Preschool	

2. Hours children are on premises:
 Monday – Friday: _____ a.m. to _____ p.m.
 Weekend: _____ a.m. to _____ p.m.
3. Are overnight stays permitted? Yes No
 If yes, please explain the circumstances: _____



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OPERATIONS

1. Average daily attendance:

0 - 6 Months	___	6 - 12 months	___	12 - 18 months	___
18 mos. - 2 years	___	2 years - 5 years	___	Over 5 years	___

2. Number of teachers:

0 - 6 Months	___	6 - 12 months	___	12 - 18 months	___
18 mos. - 2 years	___	2 years - 5 years	___	Over 5 years	___

Owner's related experience and education: _____

3. Are there any pets on the premises? Yes No

If yes, please describe (by size and breed), including how pets are separated from children:

Note: Optional Dog Liability coverage is available for In-Home Family Day Cares Only. No more than 2 dogs allowed and they must be kept separated from children at all times.

4. Are any special classes taught in dance, tumbling, gymnastics or martial arts? Yes No

If yes, please explain: _____

5. Are there any trampolines on the premises? Yes No

If yes, who is allowed to use and how is monitoring performed? _____

EMPLOYEE AND VOLUNTEER PROCEDURES AND STAFFING

1. Are the following checked on employees and volunteers prior to hiring?

- a. Personal References? Yes No
- b. Previous Employers? Yes No
- c. Criminal background? Yes No

2. Do you keep records of hiring practices (references, background checks, etc.)? Yes No

RISK MANAGEMENT

1. Are children released only to authorized persons? Yes No

2. What procedures exist for:

Accidents, medical treatment, notification to parents? _____

Dispensing of prescribed medications? _____

Illness? _____



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3. Any special needs required and/or provided? Yes No
If yes, please explain: _____
4. Are medical care releases obtained at enrollment? Yes No
5. Are there written procedures/guidelines regarding discipline? Yes No
- a. Are they communicated to parents? Yes No
- b. Are they reviewed with staff and volunteers? Yes No
6. Are there written procedures/guidelines regarding abuse issues? Yes No
7. Does the insured have emergency transportation available? Yes No
8. In case of an emergency is there a backup adult if you need to leave? Yes No
9. Are any field trips or activities conducted away from premises? Yes No
- a. If yes, fully describe, including the estimated number of trips and/or activities:

- b. Are parents required to sign "permission" forms for each field trip? Yes No
- c. Mode of transportation used for trips: _____
10. Do you utilize swimming facilities off the premises? Yes No
- a. Liability disclaimer required? (Forward copy.) Yes No
- b. Does the swimming facility provide lifeguard service? Yes No
11. Wading pool on the premises? (Optional water activities coverage available on request) Yes No
- Type of wading pool: (plastic, blow-up, etc.): _____
 - Is pool emptied daily? Yes No
 - Is pool stored away from children after use? Yes No
- (If either of these is "No", coverage is not available.)
- Note: Wading pool is defined as pool of a non-permanent structure, 2 feet or less in depth and 15 feet or less diameter, with no slides. (Swimming Pool Questionnaire is not required for wading pools.)
12. Is the outside play area fenced? (Note: A fence is required) Yes No
13. Type of playground surface: _____
14. Please list and describe all play equipment: _____

15. Are there working fire extinguishers and smoke detectors on premises? Yes No
Date last serviced: _____
16. Is there a student group accident policy in effect? Yes No
(If yes, please provide proof of insurance.)
17. Is the business located in your home? (Note: No building coverage available.) Yes No
If yes, who is your homeowners insurance company? _____
Policy #: _____ Limits: _____
18. Is the business located in a mobile home? (If yes, risk is ineligible.) Yes No
19. Have all areas that are accessible by children been child-proofed? Yes No
20. Are all televisions out of the reach of children? Yes No
If no, are they either secured or situated to prevent children from pulling on cords
or otherwise tipping them over? Yes No



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21. Are bottle warmers used? Yes No
- a. What type of bottles are used? _____
- b. If yes, how are bottles warmed? _____
- c. Where is warmer located? : _____
- d. Are cords kept out of reach of children? Yes No
- e. Are safety measures used so hot water cannot be spilled on staff or children? Yes No

PREVIOUS EXPERIENCE

1. Have any claims been filed, or are you aware of any incidents involving physical or sexual abuse that could lead to a claim? Yes No
 If yes, please explain: _____
2. Are procedures in place for reporting incidents? Yes No
3. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority? Yes No
 If yes, please explain: _____

SWIMMING POOLS – (COMPLETE WHEN APPLICABLE)

1. Please describe pool, including surrounding surface and fencing (Fencing Required):

2. Is there a self-locking gate? Yes No
3. Key necessary for pool access? Yes No
4. Are depth markings clearly indicated? Yes No
5. Are "No Running" signs posted? Yes No
6. Diving Board? Yes No
7. Water Slide? (If yes, risk is ineligible) Yes No
8. Are lifeguards employed? Yes No
 If yes, what type of certification do they possess? _____
9. Are emergency procedures in writing and reviewed with staff? Yes No
10. Please describe chemical storage:

11. Additional comments:



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IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

Applicant Signature _____ Title _____ Date _____

Producer Signature _____ Date _____

Producer Name and Address _____

EXCLUDED COVERAGE

By signing this questionnaire, you acknowledge that situations of abuse and molestation are normally excluded from coverage for child care risks. Coverage for abuse and molestation is available for an increase of premium. See below.

ADDITIONAL COVERAGES

The following coverages are available. Please list the desired coverage under the classification section of the application.

- Limited Abuse or Molestation
- Professional Liability Errors and Omissions (Removes Corporal Punishment Exclusion)
- On-premises Water Activities
- Limited Dog Coverage (Family Centers Only)
- Employee Benefit
- Hired and Non-Owned Auto (Not available if Commercial Auto Policy is in effect)

Copy of current DAYCARE license needed.

**POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE**

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, and the Terrorism Risk Insurance Program Reauthorization Act of 2007, that you have a right to purchase insurance coverage for losses arising out of acts of terrorism, as defined in Section 102(1) of the Act. The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Coverage under your existing policy may be affected as follows:

IF THIS POLICY IS A RENEWAL OF A POLICY ON WHICH YOU PREVIOUSLY REJECTED TERRORISM COVERAGE, THEN THIS POLICY HAS BEEN ISSUED WITHOUT TERRORISM COVERAGE. YOU STILL HAVE AN OPPORTUNITY TO OBTAIN TERRORISM COVERAGE. ALL YOU HAVE TO DO IS NOTIFY YOUR AGENT OF YOUR DESIRE TO ACCEPT THIS OFFER AND PAY THE ADDITIONAL PREMIUM INDICATED BELOW. IF YOU ACCEPT THIS OFFER AND YOUR POLICY IS BILLED DIRECT TO YOU, WE WILL ADD THE ADDITIONAL PREMIUM DUE TO THE BALANCE OF YOUR DIRECT BILL STATEMENT. IF YOU DO NOT USE THE DIRECT BILL OPTION, YOU WILL RECEIVE A BILL FROM YOUR AGENT.

DISCLOSURE OF FEDERAL PARTICIPATION IN PAYMENT OF TERRORISM LOSSES

IF YOU ACCEPT THIS OFFER TO ADD TERRORISM COVERAGE TO YOUR POLICY, TERRORISM COVERAGE PROVIDED BY THE POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM WILL BE PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. UNDER THIS FORMULA, IN 2007 THE UNITED STATES WILL PAY 85% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, (FOR EXAMPLE, NUCLEAR OR WAR EXCLUSIONS).

THE TERRORISM RISK INSURANCE ACT, AS AMENDED IN 2007 CONTAINS A \$100 BILLION CAP THAT LIMITS THE U.S.GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM "CERTIFIED ACTS OF TERRORISM" WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR (JANUARY 1 THROUGH DECEMBER 31) EXCEEDS \$100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED \$100 BILLION, YOUR COVERAGE MAY BE REDUCED.

SELECTION OR REJECTION OF TERRORISM INSURANCE COVERAGE

YOU HAVE THIRTY (30) DAYS FROM THE INCEPTION DATE OF YOUR POLICY TO CONSIDER THIS OFFER OF COVERAGE FOR TERRORIST ACTS. TERRORISM EXCLUSION WILL REMAIN ON YOUR POLICY AND YOU WILL NOT BE COVERED FOR LOSSES ARISING FROM TERRORIST ACTS IF WE DO NOT RECEIVE NOTICE OF YOUR ELECTION TO PURCHASE TERRORISM COVERAGE WITHIN THE TIMEFRAME STATED ABOVE.

	I hereby elect to purchase Terrorism coverage for a prospective premium of \$104.
	I hereby reject the terrorism coverage offer. I understand that I will have no coverage for losses arising from acts of terrorism as outlined in this Notice.

Policyholder/Applicant's Signature

Print Name

Date

Capitol Specialty Ins Co
Insurance Company

Policy Number

AFFIDAVIT BY ASSURED

Affidavit # _____

I/We _____ of _____ do hereby state that in _____, 20____, I/We directed _____ my/our Insurance Broker to obtain insurance against certain risks as described herein. My/Our Insurance Broker informed us that the required insurance could not be obtained from, or would not be written by, companies licensed or admitted to transact business in the Commonwealth of Massachusetts.

I/We, the Assured, was/were informed that the type and amount of insurance shown below could be obtained from certain insurers not admitted to transact business in the Commonwealth. I/We was/were further informed:

A. The surplus lines insurer with whom the insurance was placed is not licensed in this state and is not subject to Massachusetts regulations.

B. In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

Signature by Assured _____
Print Name _____
Date: _____

THIS PORTION MUST BE COMPLETED AND SIGNED BY THE ORIGINAL BROKER

Name of Insured _____ Address _____
Location of Property _____
Description: _____
Coverage: _____
Limit: _____ Premium _____

I/We hereby verify that I/We explained the foregoing to the insured and it was acknowledged that he/she understood such.

License # _____ Signature _____ Date _____

A copy of this affidavit must be kept in the original broker's file and a copy must be given to the assured at the time said copy was completed by him/her.

AFFIDAVIT BY SPECIAL BROKER

I, _____ of _____ in said county of _____
depose and say that I was engaged directly by the Assured named herein or informed by the Assured's Insurance licensed Agent/Broker that after diligent efforts, he/she is unable to procure in companies admitted to do business in this Commonwealth the amount and/or type of insurance necessary to protect the insurable interests described above. This Affidavit is made to comply with the requirements of Section 168 of Chapter 175 of the General Laws, and to authorize me as a licensed special insurance broker under said section to procure insurance for said insurable interests beyond that which companies admitted to do business in the Commonwealth are willing to write thereon. The following companies or groups are among those which have accepted all or part thereof:

Company	NAIC#	Policy #	Premium
_____	_____	_____	_____
_____	_____	_____	_____

Amendments to Affidavit: () Increase () Decrease

_____	_____	_____	_____
_____	_____	_____	_____

I hereby verify the foregoing statements and declare that they were made under the penalties of perjury.

License # _____ Signature _____ Date _____

A copy of this affidavit must be kept in the Special Brokers File and the original filed with the Division of Insurance of the Commonwealth of Massachusetts within *twenty days* following date of procurement.