

CORPORAL PUNISHMENT

- | | | |
|--|---------|------------|
| 1. What is the Applicant's policy on corporal punishment? | Allowed | Prohibited |
| If allowed, please submit a copy of the written policy concerning the use of corporal punishment. | | |
| 2. Have there ever been any claims for corporal punishment? | | Yes No |

SEXUAL ABUSE

- | | | |
|--|--|-----------|
| 1. Does the Applicant's employment process (for employees and volunteers) include verification of whether the individual has ever been convicted of any crime, including sex-related or child abuse related offenses, before an offer of employment is made? | | Yes No |
| 2. During new staff orientation, does the Applicant discuss child/sexual abuse, how to recognize the signs and what to do if a child reports that someone molested him or her? | | Yes No |
| 3. Does the Applicant perform national criminal background investigations and is a sex offender register check completed on all current employees and volunteers? | | Yes No |
| If no, please explain: | | |
| 4. How long has the Applicant been performing these checks: | | years |
| 5. For how many years does the Applicant keep these records on file after employee leaves: | | years |
| 6. Does the Applicant verify employment-related references? | | Yes No |
| 7. Does the Applicant conduct a personal interview? | | Yes No |
| 8. Does the Applicant's supervision plan monitor staff in day-to-day relationships with children both on and off premises? | | Yes No |
| 9. How is the staff monitored? Video Windows Other: | | |
| 10. Does the Applicant have written procedures for dealing with sexual abuse? | | Yes No |
| MANDATORY: Provide a copy of procedures. | | |
| 11. Has the Applicant ever had an incident which resulted in an allegation of sexual abuse? | | Yes No |
| If yes, please complete: | | |
| a) Was a claim made against the organization? | | Yes No |
| b) Is that individual still employed with your organization? | | Yes No |
| c) What changes were made to prevent recurrence? | | |

HEALTH AND SAFETY

- | | | |
|--|--------------|-----------|
| 1. Does the Applicant provide sick child or drop in services? If yes, please explain. | | Yes No |
| 2. How many children require special care and treatment? Please explain. | | |
| 3. Indicate if a file containing the following information is maintained on each child. | | |
| a. Are there Immunization records of the children being updated annually? | | Yes No |
| b. Are there records for each child indicating unusual conditions the child has? | | Yes No |
| c. Are signed releases for emergency medical treatment/dispensing of medication obtained from parents? | | Yes No |
| d. Written instructions from child's physician for dispensing of child's medication? | | Yes No |
| 4. Is food properly covered, stored and served in according to government requirements? | | Yes No |
| 5. Does the Applicant have an accident / health policy? | | Yes No |
| Is coverage mandatory for all children? | | Yes No |
| Provide carrier limits of liability: | Policy term: | |
| 6. Does the Applicant require evidence of personal medical insurance for all children? | | Yes No |
| 7. Does the Applicant have a written emergency evacuation plan in effect? | | Yes No |
| 8. Please describe the Applicant's daily check in and release procedures: | | |
| 9. Are any pets or animals kept on premises? | | Yes No |
| Describe animals, caging, and type of interaction: | | |

SECURITY

- | | | |
|---|--|-----------|
| 1. Are any of the Applicant's locations protected by security personnel? | | Yes No |
| 2. If yes, are the security personnel | | |
| a. Sub-contracted? | | Yes No |
| b. Employed? | | Yes No |
| c. Other (please explain): | | |
| 3. Does the Applicant's state permit open and/or concealed carry of weapons on your premises? | | Yes No |

- | | | |
|--|-----|----|
| 4. Does the Applicant have a written policy permitting open and/or concealed carry of firearms on any premises for which you are requesting insurance coverage? | Yes | No |
| 5. If the Applicant permits open and/or concealed carry of firearms on any premises for which you are requesting insurance coverage, please identify who you grant this permission to: | | |
| a. Staff? | Yes | No |
| b. Guests? | Yes | No |
| 6. If the Applicant does not permit open and/or concealed carry of firearms on any premises for which you are requesting insurance coverage, do all locations have signage which conspicuously identifies the building as a Gun Free Zone? | Yes | No |

AUTOMOBILE

N/A

- | | | |
|---|-----|----|
| 1. Does the Applicant provide regular transportation for children?
If yes: Maximum distance: _____ miles Minimum age: _____ | Yes | No |
| 2. Is a walk-around vehicle checklist used prior to transporting children? | Yes | No |
| 3. Are all drivers put through specialized drivers training in transporting children? | Yes | No |
| 4. How are children accounted for getting on and off the bus: | | |
| 5. How often do employees or volunteers drive their own vehicles for transporting children: | | |
| 6. Does the Applicant require evidence that they have their own auto insurance?
If yes, limit required: \$ | Yes | No |

SPECIAL ACTIVITES

Play Area

- | | | |
|---|-----|----|
| 1. Is the area fenced? | Yes | No |
| 2. Are any trampolines and inflatables present? | Yes | No |
| 3. Describe playground surface: | | |

Field Trips and Off Premises Travel

- | | | |
|--|-----|----|
| 1. How many field trips are taken per year: | | |
| 2. Describe the field trips: | | |
| 3. Are parental waivers obtained? | Yes | No |
| 4. Minimum age taken on trips: | | |
| 5. How are children transported: Child Care Vehicle Parent Other: | | |

Activities

- | | | |
|---|-----|----|
| 1. Are special classes provided? (check all that apply)
Gymnastics Dance Karate
Tumbling Birthday Parties - # of children: Other: | | |
| Please explain: | | |
| 2. Are special classes taught by an independent contractor on your premises? | Yes | No |
| 3. Does the Applicant request/maintain Certificates of Insurance from all sub-contractors? | Yes | No |
| 4. Does the Applicant have any operations other than child care?
If yes, please explain: | Yes | No |

Summer Camp

- | | |
|---|-------|
| 1. Number of children (other than children in the childcare program): | Ages: |
| 2. Number of weeks attending: | |
| 3. Number of additional staff: | |
| 4. Describe outings away from camp location: | |

Swimming Pools

- | | | |
|---|-----|----|
| 1. Does the Applicant now use or plan in the future to use swimming facilities? | Yes | No |
| 2. Is the pool you use, or plan on using, located: _____ on Applicant's premises _____ at a separate location | | |
| 3. Are all swimming pools and spas compliant with Virginia Graeme Baker Pool and Spa Safety Act? | Yes | No |
- If no, provide timetable and action plan:**

Answer the following questions for pool to be used:

- | | | |
|--|---------------------------------|--------|
| 4. Are water depths marked? | Yes | No |
| 5. What is the maximum depth: _____ feet | | |
| 6. Is there a diving board? Yes No | Is there a slide into the pool? | Yes No |
| 7. Is the pool area completely fenced? | Yes | No |
| 8. Are lifeguards present? Yes No | Is there a self-locking gate? | Yes No |
| 9. Ratio of staff to child when at pools: _____ to | | |
| 10. Minimum age of children allowed in the water: | | |
| 11. Minimum age of children in the water: | | |
| 12. Walking surface in good shape and non-slip? | Yes | No |

BUSINESS INCOME ACTUAL LOSS SUSTAINED

A. Business Incomes exposures from the following sources:	
	ACTUAL REVENUE FOR PAST 12 MONTHS
1. Total Annual Tuitions:	\$
2. Ordinary Payroll Expense*:	\$
3. Continuing Expenses:	\$
B. Total B/I Exposure for 12 months:	\$
C. Less Cost of:	
1. If excluding or limiting "Ordinary Payroll", deduct all "Ordinary Payroll" Expenses. (See note below.) If not excluding or limiting "Ordinary Payroll", leave blank.	\$
2. Other Non-continuing Expenses(describe):	\$
D. Total Deductions: (Items 1 – 2)	\$
E. Total Business Income Value: (B – D)	\$
Complete only if extra expense is requested**:	
F. Method 1: 25% of Total Revenue:	\$
G. Method 2: Calculation by Category**	
1. Rental for temporary Child Care location:	\$
2. Moving Expenses:	\$
3. Overtime / Other extra expense:	\$
4. Other(describe):	\$
H. Total Gross Extra Expense:	\$
Deduct expenses discontinued at original location because of loss:	(\$ _____)
I. Net Extra Expense: (From line F or Line H)	\$
J. TOTAL INSURABLE BUSINESS INCOME / EXTRA EXPENSE (E + I) (Agreed Amount)	\$

* Ordinary Payroll expenses include payroll, employee benefits if directly related to payroll, FICA and Medicare payments, union dues, and Workers Compensation premiums. Some points to consider in deciding whether to exclude or limit Ordinary Payroll (ie: other than officers, executives, managers and employees under contract).

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|----|--|-----|----|
| 1. | Would you lay off all your other employees in the event of a short interruption?
Describe: | Yes | No |
| | | | |
| 2. | Could you get them back when operations are restored or would they have gone elsewhere?
Describe: | Yes | No |

** Extra Expense Coverage provides additional coverage in the event of a covered loss for necessary expenses sustained during the period of restoration that you would not have incurred if there had been no direct physical loss or damage to property. For example, if it becomes necessary for you to rent another building at another unnamed location in order to continue your operations during the period of recovery. Two methodologies are being offered to determine your Extra Expense exposure. Which methodology you use is up to you.

WINTER WEATHER FREEZE-UP PROTECTION

This section must be completed by all risks that have a location in one of the following states: AR, CT, DC, DE, GA, IL, IN, KY, ME, MD, MA, MI, MO, NH, NY, NJ, NC, OH, PA, RI, SC, TN, TX, VT, VA, WV, WI

- | | | | |
|---|------|----|-----|
| 1. Fire Protection and Testing | | | |
| a. Is the building provided with an Automatic Fire Sprinkler System (AS)? | Yes | No | N/A |
| i. If yes, approximately what percentage (%) of the building is sprinklered? | % | | |
| ii. If yes, what type of sprinkler system is installed? Wet-Pipe Dry-Pipe | Both | | |
| iii. If yes, when possible, is the sprinkler piping primarily run within conditioned areas designed to ensure the temperature remains above the 45°F minimum temperature? | Yes | No | N/A |
| 1. If no, please describe freeze prevention measures (e.g. temperature monitoring, heat trace, full insulation on piping or roof): | | | |
| iv. If yes, is the testing & inspection by qualified sprinkler contractor completed within past 12 months & includes a formal winterization review? | Yes | No | N/A |
| v. If yes, are the alarms tied to a 24 hour UL listed monitoring company? | Yes | No | N/A |
| 2. Emergency Water Response (domestic and AS water lines) | | | |
| a. Are water shutoff valves (domestic and AS water lines) marked and readily accessible? | Yes | No | N/A |
| b. Are water shutoff valves exercised (closed and reopened) at least annually? | Yes | No | N/A |
| c. Is the staff qualified to respond and shut off the water main during normal business hours and off hours? | Yes | No | N/A |
| 3. Automatic Water Shutoff Devices | | | |
| a. For domestic water lines, is there a water flow detection, notification and automatic shutoff? | Yes | No | N/A |
| 4. Unused/Vacant Spaces | | | |
| a. Does Applicant have a formal process to turn off and drain domestic water lines for these spaces? | Yes | No | N/A |
| 5. Unheated Areas (attics, crawl spaces, exterior wall joists) | | | |
| a. Are all domestic water lines located in areas heated to at least 45°F? | Yes | No | N/A |
| i. If no, please describe freeze prevention measures (e.g. temperature monitoring, heat trace, full insulation): | | | |
| 6. General Comments: | | | |

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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 SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS (\$5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). (NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company.**

NAME (PLEASE PRINT/TYPER)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO
OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

Produced By: (Section to be completed by Producer/Broker)

PRODUCER

AGENCY

PRODUCER LICENSE NUMBER

AGENCY TAXPAYER ID OR SS NUMBER

ADDRESS (STREET, CITY, STATE, ZIP)

DIRECTORS & OFFICERS / EMPLOYMENT PRACTICE LIABILITY

N/A

THIS SECTION IS AN APPLICATION FOR A CLAIMS MADE POLICY. PLEASE READ YOUR POLICY CAREFULLY.

DIRECTORS & OFFICERS LIABILITY INFORMATION

1. Does the Applicant have a tax-exempt status under the U.S. Internal Revenue Code? Yes No
If no, provide an explanation:

FINANCIAL INFORMATION	CURRENT FISCAL YEAR	PREVIOUS FISCAL YEAR
Total Assets	\$	\$
Net Assets / Fund Balance	\$	\$
Annual Revenue	\$	\$
Net Revenue	\$	\$

3. Provide a list of all direct and indirect subsidiaries or any other entity or organization the Applicant controls.

Name / Type of Business	Percent the Applicant Owns/Controls	Date Created / Acquired	For Profit / Non-Profit
I.E.: ABC Foundation / Charitable Foundation	100%	01/01/2000	Non-Profit

Additional entities listed by attachment

4. Has the Applicant or any person proposed for coverage herein been the subject of, or involved in, any of the following in the past five (5) years? If yes, please attach details. Yes No
 Any disciplinary action by any regulatory agency or association? Yes No
 Any administrative proceeding charging violation of a federal or state law or regulation? Yes No
 Any other criminal actions? Yes No

EMPLOYMENT PRACTICE LIABILITY INFORMATION

1. Please provide the following employee count information
 U.S. based employees
 Total Full-Time: Total Part-Time:
 Volunteers: Temporary:
 Leased: Total Non U.S. based employees:
TOTAL SUM OF ABOVE:
2. Is any reduction of employees or change of status anticipated in the next year?
 Voluntary: Involuntary: Layoffs:
3. Does the Applicant have an employment handbook? Yes No
 4. Does the Applicant use an employment application for every potential employee? Yes No
 5. Does the Applicant use outside employment counsel for employment advice? Yes No

CURRENT COVERAGE

COVERAGES	Insurance Company	Limit of Liability	Deductible	Policy Effective Dates	Premium
D & O		\$	\$		\$
EPLI		\$	\$		\$
Fiduciary		\$	\$		\$
Workplace Violence		\$	\$		\$
Internet Liability		\$	\$		\$

WARRANTY INFORMATION

1. With respect to this coverage, has any Underwriter refused, canceled or non-renewed coverage? **(Not Applicable in Missouri) If yes, please provide details:** Yes No

2. As of this date, or the date on which the Applicant first applied for prior similar coverage and has maintained such prior similar coverage continuously in force, no person applying for this coverage is/was aware of any facts or circumstances which he or she has reason to suppose might give rise to a future claim that would fall within the scope of any of the proposed coverages for which the Applicant has applied, except: None **or as noted below:**

3. Have any claims, suits, or demands for arbitration that would fall within the scope of the proposed insurance been made against the Applicant, its predecessor(s) or any past or present principal, partner, officer or employee within the past five (5) years? None **or as noted below:**

With regard to questions 2. and 3., it is understood and agreed that if any such claim, act, error, omission, dispute or circumstance exists, then such claim and/or claims arising from such act, error, omission, dispute or circumstance is excluded from coverage that may be provided under this proposed insurance and, further, failure to disclose such claim, act, error, omission, dispute or circumstance may result in the proposed insurance being void, and/or subject to rescission.