



CHILD CARE CENTER RENEWAL SUPPLEMENT

Named Insured:

Location address:

E-mail:

Web address:

Phone number:

Is the child care center licensed?

Yes No

If licensing is NOT state required, why is the center exempt:

Has a license to operate ever been denied, suspended or revoked?

Yes No

For Business Income ALS – complete worksheet

STAFF AND CHILDREN

1.

CHILD AGE GROUP	# OF CHILDREN	AVERAGE DAILY ATTENDANCE	# OF TEACHERS
Infants, ages 0 -1			
Toddlers, ages 1 -2			
Toddlers, ages 2 - 3			
Preschoolers, ages 3 - 5			
School Age Children			

a. Is any **staff** less than 18 years old?

Yes No

If yes, indicate specific duties for each:

b. Does the Applicant use any volunteers?

Yes No

If yes, indicate specific duties for each:

c. Is a minimum of one staff member certified in first aid present at all times?

Yes No

d. OPTIONAL: If male staff, provide details of:

i) length of employment:

ii) any one on one?

Yes No

iii) duties performed, including age groups:

2. Describe any new programs added over the last year, i.e. field trips to zoo, etc.

3. Provide expiration month and year of current license:

4. Provide current policy dates of the Applicant's current Accident & Health policy:

5. Are there operable surveillance cameras in all classrooms and inside play areas?

Yes No

If yes, is the video saved? Yes No If yes, for how long:

6. Does the Applicant contract with any vendors who have contact with any children in your care?

Yes No

If yes, please explain:

7. Are there any other circumstances where adults, who are not the Applicant's employees, have access to any child in your care?

Yes No

If yes, please explain:

8. UMBRELLA : If Umbrella covers Employer's Liability

Each Accident: \$

Policy Limit: \$

Each Employee: \$

Carrier:

Term: to

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 |

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).

- | | |
|---|-----------|
| 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.

AUTOMOBILE

- | | |
|--|-----------|
| 1. Does the Applicant's organization utilize GPS fleet telematics devices?
If yes, please check off the fleet telematics being utilized:
Plug in Hard wired Mobile Phone Other: | Yes No |
| 2. What percentage of the Applicant's fleet is provided with these fleet telematics devices? | % |
| 3. Does the Applicant have a formal driving policy in place with MVR standards?
If yes: | Yes No |
| a. Is driving policy communicated in writing to all employees? | Yes No |
| b. Is a signed acknowledgement form kept on file?
If yes, please provide a copy of signed acknowledgement. | Yes No |
| c. Do driving standards include the following: | |
| No major violations including DUI, racing, hit and run, speeding in excess of 20 mph over posted speed limit, manslaughter? | Yes No |
| No more than 2 moving violations within past 3 years? | Yes No |
| No more than 1 at fault accident within past 3 years? | Yes No |
| 4. How often does the applicant check MVR reports? | |
| 5. Does the Applicant allow any newly hired drivers to operate vehicles without going through a company-specific documented driver training? | Yes No |
| 6. Describe any ongoing training provided to drivers: | |
| 7. Does the Applicant allow employees to drive personal vehicles for company purposes?
If yes: | Yes No |
| a. Are the driving policy and standards for these drivers the same as in questions 3-5? | Yes No |
| b. Does the Applicant require these employees to have adequate personal insurance limits? | Yes No |

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 STATEMENT AND SIGNATURE SECTIONS

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

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

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, PA, 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: AN ACT COMMITTED BY 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, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR 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.

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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.

APPLICABLE IN PENNSYLVANIA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM 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 SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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NAME (PLEASE PRINT/TYPE)

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

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)



CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

Name of Applicant:
Address of Applicant:
City:
Website: www:
Nature of Operations:

State: Zip:

-
1. Annual sales or revenue: \$

 2. Does the Applicant collect, store or otherwise handle any Personally Identifiable Information (PII) belonging to customers, clients, or other third parties, other than employees? Yes No
 If yes, please indicate the types of Personally Identifiable Information held (check all that apply):
 - a. Social Security Numbers, Bank or Other Financial Account Details, Driver's License or other State Identification Numbers
 - b. Non-public Medical or Healthcare Data, including Protected Health Information (PHI)
 - c. Credit or Debit Card Information

 3.
 - a. During the last three (3) years, has anyone alleged that the Applicant was responsible for damage to their computer system(s) arising out of the operation of the Applicant's computer system(s)? Yes No
 - b. During the last three (3) years, has anyone made a demand, claim, complaint, or filed a lawsuit against the Applicant alleging invasion or interference of rights of privacy or the inappropriate disclosure of Personally Identifiable Information (PII)? Yes No
 - c. During the last three (3) years, has the Applicant been the subject of an investigation or action by any regulatory or administrative agency for privacy-related violations? Yes No
 - d. Is the Applicant aware of any circumstance that could reasonably be anticipated to result in a claim being made against them for the coverage being applied for? Yes No

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