



Salt Lake City Area Office
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DAY CARE CENTER

A. General Information

Proposed Effective Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Applicant's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ County: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Physical Location of Business (if different): \_\_\_\_\_

Population within 50 miles: \_\_\_\_\_ Applicant's SS# or FEIN: \_\_\_\_\_

Other Locations Used:

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list any other names the business is or has been known by: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Producer's Name: \_\_\_\_\_

Detailed description of business activities (specifically, and by location): \_\_\_\_\_

Applicant is:  Individual  Corporation  Partnership  Joint Venture  Other: \_\_\_\_\_

Is this a new business?  Yes  No

Please list the business owner(s) of the business applying for insurance and identify how many years experience the owner(s) has in this type of business: \_\_\_\_\_

Please list the manager(s) of the business applying for insurance and identify how many years experience the manager(s) has in this type of business: \_\_\_\_\_

Annual Payroll: \$ \_\_\_\_\_ Total Number of Employees: \_\_\_\_\_ Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_

Please describe the business's drug policy and what the procedure is when an applicant or employee fails a drug test: \_\_\_\_\_

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services?  Yes  No

If yes, please tell us:

Employee Name: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Business Telephone No.: \_\_\_\_\_

Fax: \_\_\_\_\_ Years with Company: \_\_\_\_\_

Employee's Responsibilities: \_\_\_\_\_

**B. Insurance History**

Who is your current insurance carrier (or your last if no current provider)? \_\_\_\_\_

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

Has the Applicant or any predecessor ever had a claim?  Yes  No

Completed Claims and Loss History form attached (REQUIRED)?  Yes  No

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?  Yes  No

If the standard markets are declining placement, please explain why: \_\_\_\_\_

**C. Other Insurance**

Please provide the following information for all other business-related insurance the Applicant currently carries.

	1	2	3
Coverage Type			
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

**D. Desired Insurance**

Per Act/Aggregate OR Per Person/Per Act/Aggregate

<input type="radio"/>	\$50,000/\$100,000	<input type="radio"/>	\$25,000/\$50,000/\$100,000
<input type="radio"/>	\$150,000/\$300,000	<input type="radio"/>	\$75,000/\$150,000/\$300,000
<input type="radio"/>	\$250,000/\$1,000,000	<input type="radio"/>	\$100,000/\$250,000/\$1,000,000
<input type="radio"/>	\$500,000/\$1,000,000	<input type="radio"/>	\$250,000/\$500,000/\$1,000,000
<input type="radio"/>	Other: _____	<input type="radio"/>	Other: _____

Self-Insured Retention (SIR):  \$1,000 (Minimum)  \$1,500  \$2,500  \$5,000  \$10,000

**E. Business Activities**

- 1. Gross Receipts for the past 12 months: \$ \_\_\_\_\_  
Gross Receipts estimated for the next 12 months: \$ \_\_\_\_\_
- 2. Premises Information:
  - Occupied as Dwelling  Constructed for Day Care Operation
  - Constructed as Dwelling and Converted to Day Care Center
  - Constructed as Commercial Building and Converted to Day Care Center
  - Other (please explain): \_\_\_\_\_
- 3. Number of Stories \_\_\_\_\_ Construction Class \_\_\_\_\_

**F. Safety Information:**

- 1. Number of Fire Extinguishers on Premises \_\_\_\_\_
- 2. Is the Fire Extinguisher inspected  Monthly  Quarterly  Other \_\_\_\_\_
- 3. Number of Exits \_\_\_\_\_
- 4. Smoke Detectors?  Yes  No
- 5. Building Sprinkler System?  Yes  No
- 6. Fire Alarm?  Yes  No
- 7. Are premises inspected for building codes and health standards by local safety and health authorities?  
 Yes  No
  - a. Date of Last Inspection: \_\_\_\_\_
  - b. Name of entity conducting inspection: \_\_\_\_\_
  - c. Were there any violations discovered or citations issued?  Yes  No  
If yes, please describe: \_\_\_\_\_
  - d. Have violations been corrected?  Yes  No
- 8. Is Applicant Licensed?  Yes  No  
If yes, type of license \_\_\_\_\_  
License number: \_\_\_\_\_
- 9. Do you require teachers to be certified?  Yes  No  
Identify type(s) of Certification required: \_\_\_\_\_
- 10. What is maximum number of children permitted by license? \_\_\_\_\_
- 11. What is maximum number of children on premises at any one time? \_\_\_\_\_
- 12. When are children are on premises? \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  
Number of days per week: \_\_\_\_\_
- 13. Indicate the number of children in each age group and the number of attendants for each age group.

AGE GROUP	NO. OF CHILDREN	NO. OF ATTENDANTS
1 Month to 12 Months		
12 Months to 24 Months		

2 Years to 4 Years		
4 Years to 6 Years		
Over 6 Years		

13. Are children with physical or emotional disabilities accepted?  Yes  No

If Yes, please explain. \_\_\_\_\_

Identify types of disabilities: \_\_\_\_\_

14. Attach pictures/diagrams, etc. of equipment and facility.

15. Describe special exercise equipment used, e.g. trampoline, etc. \_\_\_\_\_

16. Is the yard fully fenced?  Yes  No

17. Are special classes taught, e.g. gymnastics, tumbling, dance, swimming, etc.?  Yes  No

a. If yes, please describe: \_\_\_\_\_

18. Is there a swimming pool on premises:  Yes  No

If yes,

a. Is it enclosed?  Yes  No

b. Include size, depth at each end number and height of diving boards: \_\_\_\_\_

c. Are there animals on the premises:  Yes  No

If yes, explain: \_\_\_\_\_

23. Are off premises field trips conducted?  Yes  No

If yes,

a. How often?  Weekly  Monthly  Other: \_\_\_\_\_

b. How are children transported? \_\_\_\_\_

c. Do you require driver of vehicle to have chauffeur license?  Yes  No

d. Avg. # of miles traveled: \_\_\_\_\_

e. Describe field trips: \_\_\_\_\_

24. Attach a list of all attendants/teachers with a description of his/her experience, educational background and certificates and/or licenses.

25. Describe procedures for the list below including process to notify parents/guardians

Accidents: \_\_\_\_\_

Illness: \_\_\_\_\_

26. Is a medical care release form signed by parent/guardian required?  Yes  No

If yes, attach copy of release.

27. Are staff required to be CPR and/or First Aid certified?

Yes  No

28. Provide copy of any training manual used.

**REPRESENTATIONS AND WARRANTIES**

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

Applicant:

Agent/Broker:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name