



## CHILD CARE SOLUTIONS APPLICATION

*All questions must be fully and completely answered. If there is not enough room in the space provided, a separate page(s) may be attached. Please mark "N/A" any questions that does not apply to your operation.*

NOTE: In applying for coverage, applicant agrees that, in the event of covered losses, applicant will be required to be defended by the Company's appointed attorneys and that the deductible shall apply to each loss including (whether or not loss payment is made) adjusting expenses, investigation costs, and legal fees. If however, applicant elects to handle a claim without in any way involving the Company's attorney, then no coverage for such claim is afforded the applicant under the Policy.

**1. GENERAL INFORMATION**

Name of Applicant: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City/State Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Contact Person for Inspection: \_\_\_\_\_  
 Website: \_\_\_\_\_

**2. LOCATION ADDRESSES (please attach schedule of locations if necessary)**

Location 1 Address: \_\_\_\_\_  
 Location 2 Address: \_\_\_\_\_

**3. List all subsidiaries (attach a list if more space is required)**

<u>Name</u>	<u>Type of Operation</u>	<u>% of Ownership</u>	<u>Date Acquired</u>	<u>Domestic or Foreign</u>

Do you wish coverage to include all subsidiaries?  Yes  No

If yes, include complete list of Directors and Officers of each subsidiary for which coverage is requested.

**4. APPLICANT IS:**

Individual       Partnership       Non Profit:       For Profit:  
 Government       Other (Describe: ) \_\_\_\_\_

Annual Budget: \_\_\_\_\_ Years Operational under Current Ownership: \_\_\_\_\_  
 Are you receiving any public funds:  Yes  No      If yes, for what? \_\_\_\_\_

**5. STAFFING AND OPERATIONS: PLEASE ATTACH A COPY OF YOUR EMPLOYMENT APPLICATION**

Profession	# OF EMPLOYEES		# OF NON EMPLOYEES	
	Full Time	Part Time	Volunteers	Consultants
Day Care Providers	_____	_____	_____	_____
Drivers	_____	_____	_____	_____
Teachers	_____	_____	_____	_____
Others (Specify Position)	_____	_____	_____	_____

Do any staff members hold the following credentials?

- |                                    |                              |                             |                         |
|------------------------------------|------------------------------|-----------------------------|-------------------------|
| National Administrator Credential? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ |
| Certified Childcare Professional?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ |
| Child Development Associate?       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ |
| RN or Medical Degree?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ |

**6. LICENSING**

- Is the center licensed? **(Attach licenses for all locations)**  Yes  No
- Has a license to operate ever been denied, suspended or revoked?  Yes  No  
 If yes, please provide details. \_\_\_\_\_
- Have you ever been brought up for a compliance hearing?  Yes  No  
 If yes, please provide details. \_\_\_\_\_
- Is the center accredited?  Yes  No
- If yes, which organization? : \_\_\_\_\_

STAFF/CHILD RATIO:			
Ages	#Children Licensed For	# of Care Providers	Group Size
0-1 Year			
1-2 Years			
2-3 Years			
3-4 Years			
4-5 Years			
5-6 Years			
Over 6 Years			
Totals			

Max. age accepted in enrollment \_\_\_\_\_

Total # licensed all locations \_\_\_\_\_ Average # of Children in all Facilities (daily) \_\_\_\_\_

**CHILD CARE:**

- a. Is the staff required to be licensed by applicable state and/or local authorities?  Yes  No  
 If not, do you require specific qualifications for employment? \_\_\_\_\_
- b. How many care providers are CPR and first aid certified? \_\_\_\_\_
- c. Does the center care for children with special needs?  Yes  No If yes, please provide details \_\_\_\_\_  
 \_\_\_\_\_
- d. Are there pets on premises? Please list type and breed. \_\_\_\_\_
- e. Do you allow children to be dropped off that are not enrolled in the program? \_\_\_\_\_

**7. SEXUAL ABUSE**

- a. Does your staff (paid and volunteer) employment application include:
- Questions about whether the individual has ever been convicted/pled guilty to or pled no contest to or admitted to any crime, but not limited to, sex-related or child abuse related offenses?  Yes  No
  - A signed statement verifying the applicant's understanding that falsifying information is grounds for dismissal and/or other action?  Yes  No
  - A written release giving consent to verify information provided on the application and to search criminal history and registry records?  Yes  No
- b. Does your screening/hiring process include the following:
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| • Personal reference checks?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Employment related reference checks?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Comprehensive personal interviews?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Criminal record checks?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Fingerprinting?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Child abuse registry checks?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Primary source verification of licensing/certification? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Primary source verification of educational status?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- c. Do you have a plan of supervision that monitors staff in day-to-day relationships with children?  Yes  No
- d. Do you discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if abuse is suspected?  
 Yes  No
- e. Do you require staff to sign a code of conduct which clearly defines unacceptable behavior?  Yes  No
- f. Do you have a crisis management plan for dealing with staff personnel, victim, parents, authorities and media if you have an incident of abuse?  Yes  No
- g. Have you ever had an incident or claim which resulted in an allegation of sexual or physical abuse?  Yes  No  
If yes, please provide details on ACORD application.

**8. ACTIVITIES AND ENTERTAINMENT:**

- a. Do you participate in field trips?  Yes  No  
How many annually? \_\_\_\_\_  
Are permission slips signed by the parent or guardian for each trip off premises?  Yes  No  
Please describe trips: \_\_\_\_\_

b. At what age can children participate in a field trip without a parent/guardian? \_\_\_\_\_

c. Your adult to child ratio on field trips is \_\_\_\_\_ adult for every \_\_\_\_\_ children.

- d. Do you utilize swimming facilities?  Yes  No  On Premises  Off Premises

If no, do you anticipate swimming facilities in the future?  Yes  No

If yes, explain below:

- Is there a self latching gate?  Yes  No
- Is there a 4' fence around the pool?  Yes  No
- Is there a pool bottom drain cover?  Yes  No
- Are pool depths marked?  Yes  No
- Is there adequate supervision?  Yes  No Ratio @ Pool \_\_\_\_\_
- Is the storage of pool chemicals secure?  Yes  No
- Is the staff trained in water safety?  Yes  No How many? \_\_\_\_\_
- Minimum age allowed in water? \_\_\_\_\_

- e. Is there a playground?  Yes  No

Is the playground fenced?  Yes  No

Describe playground surfaces & depths: \_\_\_\_\_

Are there trampolines?  Yes  No

Is the playground equipment properly maintained and checked on a specified schedule?  Yes  No

Do the play equipment and toys meet the consumer safety code requirements?  Yes  No

**Please list any additional interests: (attach separate sheet if necessary)**

Name: \_\_\_\_\_ Insurance Interest: \_\_\_\_\_

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

**9. SAFETY/RISK MANAGEMENT**

a. Do the following written plans or protocols exist:

- Emergency evacuation plan including monthly drills?  Yes  No
- Maintenance plan for fire extinguishers and smoke detectors?  Yes  No
- Child release protocol?  Yes  No
- Child/sexual abuse prevention program including training?  Yes  No
- First aid/CPR training?  Yes  No
- Dispensing of medication, including storage of same and training?  Yes  No
- Written playground safety program including documented weekly inspections?  Yes  No
- Written fire safety program including documented weekly inspections?  Yes  No

- b. Do you limit access to your facility via card or code access?  Yes  No

- c. Do you require signing of roster by both parent & staff at drop-off and pick-up time?  Yes  No
- d. Do you have monitoring system (e.g., cameras) in your facility?  Yes  No
- e. Do you maintain medical history and immunization records on all children?  Yes  No
- f. Do you obtain signed releases for emergency medical treatment?  Yes  No
- g. Do you have a policy on drug and alcohol use/abuse?  Yes  No  
If yes, describe \_\_\_\_\_

- h. Do you have a formal incident reporting process?  Yes  No

**10. AUTO**

Hired/Non-Owned Auto Liability Coverage (attach MVR's and driver lists for all drivers)

- a. Does applicant own any autos?  Yes  No  
Are any of these vehicles 12-15 passenger vans?  Yes  No
- b. Does applicant currently have a Commercial Auto policy?  Yes  No
- c. Do your criteria for qualified drivers include safety training and observation (of driving skills)?  Yes  No
- d. Do you routinely transport children?  Yes  No
- e. Do you only transport children in buses?  Yes  No
- f. Are employees permitted to use their own vehicles to transport children?  Yes  No  
 Non-owned auto liability  Hired/Non-owned auto liability
- g. What is the minimum age of drivers permitted to transport children? \_\_\_\_\_
- h. Do all your drivers have a CDL with passenger endorsement, or CDL license-class C?  Yes  No
- i. Do your employees and/or volunteers use their own vehicles on your behalf?  Yes  No If yes, please give details on frequency and use: \_\_\_\_\_

**11. REPRESENTATIONS**

- a. Is coverage desired for non-employee consultants?  Yes  No  
**IF COVERAGE IS DESIRED, PLEASE LIST NAMES AND TITLES ON A SEPARATE SHEET.**
- b. Are any medications dispensed by the Applicant?  Yes  No  
**IF YES, ATTACH A LIST ADVISING WHAT MEDICATIONS ARE DISTRIBUTED, BY WHOM, FOR WHAT PURPOSE AND HOW THE MEDICATIONS ARE SECURED.**
- c. Is ANYONE applying for insurance under this policy aware of any state, federal, local code or professional violations, unethical misconduct, incompetence or negligence?  Yes  No  
**IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.**
- d. Is ANYONE applying for insurance under this policy aware of any circumstances involving sex or sexual abuse/molestation with any children, former child-clients or relatives thereof?  Yes  No  
**IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.**
- e. Does the applicant enlist the services of volunteers (a volunteer is someone who does work or provides services for the applicant, but is not an employee and includes unpaid consultants and board members)?  Yes  No  
If yes:  
Do they go through the same screening process as employees?  Yes  No  
Please provide the estimated number of annual volunteer days for all locations: \_\_\_\_\_
- f. Has license ever been suspended or revoked?  Yes  No  
If yes, please explain: \_\_\_\_\_  
**PLEASE ATTACH COPY A OF ALL LICENSES HELD AND ATTACH LATEST HEALTH DEPARTMENT INSPECTION**
- g. Are complete records kept on all children?  Yes  No  
Where are they stored and how are they secured? \_\_\_\_\_

**12. RECORD OF EXISTING INSURANCE**

COVERAGE	COMPANY	LIMITS	PREMIUM	EFFECTIVE DATE	RETRO DATE
Professional Liability					
General Liability					
Property/Auto					
Excess and/or Umbrella					

If no insurance exists, is this a new venture?  Yes  No

If no, please explain: \_\_\_\_\_

Is expiring professional liability coverage on a claims made policy?  Yes  No Retroactive Date: \_\_\_\_\_

If yes, do you desire prior acts coverage?  Yes  No

**PLEASE PROVIDE PROOF OF UNINTERRUPTED CLAIMS MADE COVERAGE.**

Does this policy provide Physical/Sexual Abuse Exclusion?  Yes  No

If yes, is this a sublimit?  Yes  No Limit: \_\_\_\_\_

Is coverage claims made?  Yes  No Retro Date: \_\_\_\_\_

**13. CLAIMS HISTORY**

Has the applicant had ANY Professional Liability or General Liability claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past 5 years?  Yes  No

**IF YES, PLEASE DESCRIBE IN DETAIL - DATE CLAIM REPORTED, DATE OF LOSS, ALLEGATIONS, AMOUNT RESERVED/PAID, and CURRENT STATUS (OPEN OR CLOSED).**

The undersigned authorized representative of the applicant declares that (1) the statements set forth herein are true, and (2) if the information supplied on this application changes between the date of this application and the effective date of the insurance, the undersigned will immediately notify AFC INSURANCE of such changes, and AFC INSURANCE may withdraw or modify any outstanding quotations and/or agreement to bind the insurance. Furthermore, signing this form does not bind the applicant or the company to complete this insurance.

**NOTICE:** COVERAGE IS WRITTEN WITH A NON-ADMITTED CARRIER, PRODUCER WARRANTS THAT ALL INSURANCE REQUIREMENTS OF APPLICANT'S HOME STATE HAVE BEEN OR WILL BE COMPLIED WITH, INCLUDING MAKING THE SURPLUS LINES FILING AND SUBMITTING SURPLUS LINES FEES AND TAXES, WHERE APPLICABLE.

**NOTICE TO ARKANSAS APPLICANTS:** "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRADULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

**NOTICE TO COLORADO APPLICANTS:** "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPELTE, 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 POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WTIHIN THE DEPARTMENT OF REGULATORY AGENCIES."

**NOTICE TO FLORIDA APPLICANTS:** "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 THE THIRD DEGREE."

**NOTICE TO KENTUCKY APPLICANTS:** "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."

**NOTICE TO MINNESOTA APPLICANTS:** "A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."

**NOTICE TO NEW JERSEY APPLICANTS:** "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

**NOTICE TO NEW YORK APPLICANTS:** "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, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

**PLEASE REMEMBER TO ATTACH ALL SEPARATE STATEMENTS, LOSS RUNS, COPY OF LICENSE HELD, HEALTH DEPARTMENT INSPECTIONS, INCLUDING THE FOLLOWING:**

- EMPLOYMENT APPLICATION
- FOUR YEAR LOSS RUN
- LICENSES FOR ALL LOCATIONS
- MVR'S AND DRIVER LISTS IF HIRED AND NON-OWNED AUTO IS REQUESTED

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Applicant/Owner/President)

Title: \_\_\_\_\_

Please return to:  
**AFC INSURANCE**  
95 Highland Avenue, Suite 150  
Bethlehem, PA 18017  
Tel: (877) 456-5323  
Fax: (610) 974-8574