



THE EQUESTRIAN GROUP

A division of Allen Financial Insurance Group

EQUINE ANIMAL SERVICES APPLICATION

Date:

Renewal of #

Agency Name:	Program Administrator: Allen Financial Insurance Group	Direct 800-874-9191 FAX 602-992-8327
Producer Name:	<input type="checkbox"/> Commercial General Liability	
Producer Email:	<input type="checkbox"/>	
Producer Phone:		
Effective Date:	Expiration Date:	Quote Desired By:

Name of Applicant:

Mailing Address:

City, State, Zip:

<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> LLC	<input type="checkbox"/> Corporation	<input type="checkbox"/> Not For Profit
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Inspection Contact:	Email:
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Telephone # (Required):	Website:
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Social Security / Federal Tax ID:

Method of Payment: <input type="checkbox"/> Agency Bill	Payments: <input type="checkbox"/> Annual
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Type of Activities Offered (Check all that apply)

- | | | | |
|--|---|--------------------------------------|---|
| <input type="checkbox"/> Equine Hydrotherapy | <input type="checkbox"/> Equine Massage Therapy | <input type="checkbox"/> Equine PEMF | <input type="checkbox"/> Farrier Services |
| <input type="checkbox"/> Equine Grooming | <input type="checkbox"/> Equine Security Services | <input type="checkbox"/> Farrier | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Other | | | |

Industry Affiliations & Accreditations? Yes No

Name of Organization

How long has the applicant been in this field?	Gross receipts? \$
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Is this new business to your agency?	How long have you known the applicant?
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I/We understand and agree that any misstatement of warranty or fact on this application shall be considered a violation of coverage afforded under any policy issued on the basis of this application. The insured assigns as security for the total premium and/or fees payable any and all unearned premiums which may become payable. I/We agree to pay reasonable attorneys fees, costs and expenses necessarily incurred if suit or collection becomes necessary.

Applicant's signature:	Agent's signature:
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Date:	Date:
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AmRisk Insurance Services A member of Allen Financial Insurance Group
 13880 N Northsight Blvd Ste C109 Scottsdale, AZ 85260 602.992.1570 FAX 602.992.8327
 Email: ballen@amriskusa.com Website: www.amriskusa.com

OPERATIONS OVERVIEW

Additional Premises Operations? (Check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Farming Operations | <input type="checkbox"/> Farm "Pick Your Own" sal | <input type="checkbox"/> Retail Sales | <input type="checkbox"/> Boarding - Training |
| <input type="checkbox"/> Riding Instruction | <input type="checkbox"/> RV Hookups / Campsites | <input type="checkbox"/> Kennels | <input type="checkbox"/> Wagon Rides |
| <input type="checkbox"/> Day or Overnight Camps | <input type="checkbox"/> Special Events | <input type="checkbox"/> Pony Ride / Petting Zoo | <input type="checkbox"/> Trail Rides |
| <input type="checkbox"/> Other | | | |

Does the Applicant operate any type of "At Risk" program defined as persons involved in a program as a result of local, state, federal government or court mandated program including but not limited to criminal rehabilitation or community service sentencing. Yes No

If Yes, provide details including copy of agreement with assigning agency.

Number of employees: Full time _____ Part time _____ Annual payroll \$ _____

Does the Applicant carry Workmen's Compensation insurance? Yes No

Licensed by ***

Attach copy of state or governmental licenses

If Yes, has your license ever been suspended or revoked? Yes No If Yes, include explanation.

Is this program part of any school curriculum, recreational center or in any way associated with a city, county or state program? Yes No

If YES Please explain

Is there 24 hour supervision of facility Yes No Yes No

If No explain

Does the Applicant use any unlicensed motorized vehicles i.e. Golf Carts, ATV, Scooters, etc? Yes No

Use of any vehicle is limited to Applicant and Employees only.

Do you provide transportation to and from the facility? Yes No

If YES Please explain

Do you have a written and enforced Smoking Policy? Yes No

Are "no smoking" signs posted in areas not designated for smoking? Yes No

Does the Applicant have any exchange labor working for the Facility? Yes No

If YES explain

Bodily Injury to any person arising out of and in the course of a person acting on the behalf of the named insured, whether through employment, voluntary or otherwise is not covered by general liability in this policy. Coverage for bodily injury to employees is provided for in accident medical coverage and workman's compensation coverage.

Has any staff member had any history of violence or criminal behavior? Yes No

Funding sources: Check all that apply

- Client Fees Federal State County Donations Other

Annual operating budget: \$ _____ Annual Gross Receipts: \$ _____

COMMERCIAL LIABILITY SECTION

Coverage	Limits of Liability			
Bodily Injury and Property Damage Liability	\$ 1,000,000	Each "Occurrence" Limit		
	\$ 2,000,000	General Aggregate Limit		
Personal and Advertising Injury Liability	\$ 1,000,000	Each "Occurrence" Limit		
	\$ 2,000,000	General Aggregate Limit		
Medical Payments	\$ 5,000	Any One Person Limit		
	\$ 25,000	Each "Occurrence" Limit		
Damage to Property of Others	\$ 100,000			
Excess Liability Limit	\$			
Equine Commercial Liability? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Property / Farm Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Complete ACORD / Farm application	Automobile Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Submit ACORD automobile application			
Excess Liability Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Submit ACORD application				
ADDITIONAL INTERESTS	Affiliated or subsidiary companies to be insured	Relationship		
	Additional Insureds	Interest	Sec.I	Sec.II
	Additional Insureds	Interest	Sec.I	Sec.II

RELEASES / WAIVERS / PROFESSIONAL LIABILITY

Submit the following if application to your operation

- Medical release form being used
- Client Hold Harmless / Liability Release
- Volunteer Hold Harmless / Liability Release
- Professional liability insurance certificate
- Employee / Volunteer handbook, rules, guidelines, safety training

MANAGEMENT PRACTICES

1.	Is the staff required to report all incidences that may result in a claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are written records of all incidences kept by the administrator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are all incidences reviewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you have a formal written safety program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Does the facility have a written emergency evacuation plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Is there always someone trained in first aid on the premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Are staff members trained in specialty procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Do you have any security procedures in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Guards <input type="checkbox"/> Video Cameras <input type="checkbox"/> Other	
10.	Do you have sign in/sign out procedures for:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Staff <input type="checkbox"/> Clients <input type="checkbox"/> Visitors / Public	

Loc. #	Sec.I	Sec.II	Locations to be Insured (Include County and Zip Code)	# of Acres	Check if NO Buildings	Insured's Interest		
						Owner Occupant	Lessee	Lessor
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR CARRIER INFORMATION

Line	Category	Year	Year	Year
LIABILITY	Carrier	•		
	Policy No.			
	Policy Type			
	BI/CSL			
	Total Premium	•		

LOSS HISTORY

Check here if none

Enter all claims or occurrences that may give rise to claims for 5 years

Date of Occurrence	Line	Type/Description of Occurrence or Claim	Date of Claim	Amount Paid	Amount Reserved	Claim Status
						<input type="checkbox"/> Open
						<input type="checkbox"/> Closed
						<input type="checkbox"/> Open
						<input type="checkbox"/> Closed
						<input type="checkbox"/> Open
						<input type="checkbox"/> Closed

Has any policy been cancelled? Yes No Non-renewed? Yes No Declined? Yes No

Have you ever contributed to a claim or accident or found negligent in any past equine activity? Yes No

Explain yes answers:

EMPLOYEE / VOLUNTEER EXPERIENCE

List all personnel including instructors, employees, therapists, volunteers and trainees

Names of W2 employees / volunteers to be insured under this policy.	License – Certification - Experience	Owner, Partner Or Officer ?	W2 Employee or Volunteer ?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
*For any Paraprofessionals (unlicensed or uncertified please indicate job title and duties			

Notes & Comments:

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