



Worldwide Facilities, Inc.

SPECIAL NEEDS SCHOOL QUESTIONNAIRE

Please attach an Acord® Application

Name of organization: \_\_\_\_\_

Website address (URL): \_\_\_\_\_

Date Business Operations Started: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Form of Insurance: Professional Liability: [ ] Occurrence [ ] Claims Made
Commercial General Liability: [ ] Occurrence [ ] Claims Made

Applicant is a: Corporation [ ] Partnership [ ]
Professional Association [ ] Sole Proprietorship [ ]
Joint Venture [ ]

Other (Please Explain) \_\_\_\_\_

Applicant Operates: For Profit [ ] Not For Profit [ ]

- 1. Total annual gross revenue/operating budget: \$ \_\_\_\_\_
2. Total payroll of employees: \$ \_\_\_\_\_
3. Number of students in each age group: \_\_\_ age 0-5 \_\_\_ age 6-12 \_\_\_ age 13-18 \_\_\_ age 19+
4. What are the dates of your current school term and next school term? \_\_\_\_\_
5. How many teachers? \_\_\_\_\_
6. Is school licensed? YES [ ] NO [ ]
7. Is this a charter school? YES [ ] NO [ ]
8. If school was built prior to 1980, has premises been inspected and certified lead free? YES [ ] NO [ ]
9. Are any in-home services offered? YES [ ] NO [ ]
10. Is the building handicap accessible? YES [ ] NO [ ]
11. Is a security system in place to control and monitor entrances, and exits of students and visitors? YES [ ] NO [ ]
12. Are there metal detectors at all school entrances? YES [ ] NO [ ]
13. Do you use security officers? YES [ ] NO [ ]
If yes, are security officers armed? YES [ ] NO [ ]
14. Is restraint of students allowed? YES [ ] NO [ ]
If yes, how many incidents of restraint have occurred in the past year? \_\_\_\_\_
15. Is corporal punishment coverage desired? YES [ ] NO [ ]
16. Are all medications kept in a locked area? YES [ ] NO [ ]
17. Does school have any stadiums, bleachers or grandstands? YES [ ] NO [ ]
18. Do you have an outdoor play area? YES [ ] NO [ ]
If yes,
a. Does the value of your outdoor equipment, including surfacing, exceed \$25,000? YES [ ] NO [ ]
If yes, attach a schedule of locations with value at each.
b. Was all equipment manufactured by a commercial manufacturer? YES [ ] NO [ ]
c. Was all equipment installed by an insured contractor? YES [ ] NO [ ]
19. Indicate any of the following activities offered:
[ ] Archery [ ] Downhill skiing [ ] Off Premises Water Activities
[ ] Baseball/Basketball [ ] Football-flag [ ] Riflery
[ ] Boxing/ Martial Arts -Contact [ ] Football-tackle [ ] Soccer
[ ] Boxing/Martial Arts- Non-Contact [ ] Gymnastics [ ] Track and Field
[ ] Climbing/Rappelling/Ropes Course [ ] Lacrosse/Rugby [ ] Wrestling
[ ] Equine/Horseback Riding
[ ] Swimming or Diving-complete Pool questionnaire if there is a pool on school premises.
[ ] Other: \_\_\_\_\_

20. Do you provide accident insurance for students? YES  NO

**If yes:**

a. Insurance company name: \_\_\_\_\_ Policy number : \_\_\_\_\_  
 Policy period: \_\_\_\_\_ Limits: \_\_\_\_\_

b. Accident insurance:  
 applies to all students       applies to sports participants       is optional, at student's expense

21. Is your school's primary purpose or mission to serve any of the following student groups:  
 Developmentally impaired     Learning impaired                       Physically impaired  
 Emotionally impaired, including mentally ill, suicidal, violent and/or oppositionally defiant

22. Is auto coverage desired for owned and/or non-owned vehicles? YES  NO

**If yes, complete the Auto Questionnaire and provide Acord® Auto applications**

**23. As respects to abuse coverage:**

a. Have any claims been filed, or allegations been made, against your organization or anyone working on behalf of your organization alleging abuse? YES  NO   
 b. Are you aware of any occurrences that could lead to a claim? YES  NO

24. Does your facility have written policies that require known or suspected abuse incidents be reported to proper authorities? YES  NO

**Abuse coverage currently in place:**

None  
 Occurrence                       Included in GL    or     Submit: \_\_\_\_\_  
 Claims Made                       Included in GL    or     Submit: \_\_\_\_\_

Total number of clients: \_\_\_\_\_

	Employees	Volunteers
a. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. State <b>10-digit fingerprint</b> criminal record check?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Federal <b>10-digit fingerprint</b> criminal record check if in state less than 5 years?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal <b>10-digit fingerprint</b> criminal record check regardless of time in state?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Are all controls indicated in e, f & g required before client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

**Federal checks require a second set of 10-digit fingerprint cards**

25. **As respects professional liability:** Is professional liability coverage desired? YES  NO

26. Is your organization aware of any circumstances which may result in any claim being made or any claims or suits which have been made during the past five years, against the entity or any of its past or present officers or employees? YES  NO   
 If yes, explain: \_\_\_\_\_

27. Has any similar insurance for the entity, present officers or employees ever been cancelled? YES  NO   
 If yes, explain: \_\_\_\_\_

28. **Professional coverage currently in place:**

- None  
 Occurrence       Sublimit: \_\_\_\_\_  
 Claims Made       Sublimit: \_\_\_\_\_

29. Prior professional liability insurance carrier: \_\_\_\_\_

30. Indicate all services applicable:

- Any invasive procedure       Psychiatric Shock Therapy       Catheterization  
 Obstetrical/Gynecological       Feeding Tube Maintenance       X-rays  
 Any procedures not supported by the American Medical Association (procedures that are experimental, are not used as prescribed by the AMA or are unsupported by AMA accepted clinical research)  
 Alternative or Complementary Medical practices (e.g. Acupuncture, Chiropractic, Homeopathy, Massage, Mental Healing, Naturopathy, etc.)

Explain any services indicated: \_\_\_\_\_

31. Describe any other health care services provided by the organization: \_\_\_\_\_

32. List the number of employed medical professionals:

Degree	Full-time	Part-time (less than 15 hrs/wk)
Medical Doctors		
Psychiatrist		
RN		
LPN / CNA / Nurse Aides		
Therapists (e.g., Speech, Occupational, Physical)		
<b>Professional Educators:</b>		
Classroom Teachers		
Teacher Aides, Student Teachers, Daycare Workers		
Special Education Teachers		
Guidance Counselors, Vocational Counselors, Psychological Counselors		
School Nurses		
Other professionally trained educators (including administrators)		

33. Of the professionals listed, do any carry their own professional liability insurance and want to be excluded from coverage under this policy? YES  NO   
**If yes, list all individuals and position:** \_\_\_\_\_

34. List the names of any Medical Doctors or Psychiatrists that require professional coverage while performing job duties for the named insured. Note these individuals must be scheduled on the policy in order for coverage to apply: \_\_\_\_\_

**AUTO COVERAGE:**

35. Does your organization own or lease vehicles? **YES**  **NO**
36. Are all owned or leased vehicles being submitted to us for coverage? **YES**  **NO**   
**If yes, attach Acord® Auto applications.**
37. Do you provide transportation to and from your facility? **YES**  **NO**
38. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following:  
 a. More than 2 moving violations and/or accidents within a 3 year period? **YES**  **NO**   
 b. Reckless driving, DUI or any felony driving conviction within a 5 year period? **YES**  **NO**
39. Are any vehicles equipped with wheelchair lifts? **YES**  **NO**   
**If yes, have employees been trained in use?** **YES**  **NO**
40. Is **hired auto liability** coverage desired? **YES**  **NO**   
**If yes, does your annual vehicle rental expense exceed \$2,500?** **YES**  **NO**   
**If yes, what is your annual vehicle rental expense?** \$ \_\_\_\_\_
41. Is **non-owned auto liability** coverage desired? **YES**  **NO**   
**If yes, total number of: employees** \_\_\_\_\_ **volunteers** \_\_\_\_\_
42. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization:**

Number of Volunteers	Number of Employees	Usage	Average trips per week (total for all employees & Volunteers)	Annual MVR Required?	Proof of Personal Auto Insurance Required on a Renewal Basis?	100/300 or 300 CSL Personal Auto Limits Required?
		Errands		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
		Transport Clients		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
		Home visitation		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
		Home Meal Delivery		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
		Other _____		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>

**Claims History**

43. Are you aware of any circumstance which may result in a general liability (including Abuse and Molestation) or professional liability claim or suit being made against you? **YES**  **NO**

44. Please list the general liability (including Abuse and Molestation) and/or professional liability carrier for each of the past five years. If none, state "none."

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Policy Period	Claims-Made? <input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date
						<input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date
						<input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date
						<input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date
						<input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date
						<input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date

Please attach a copy of the following with your submission:

- i Most recent state survey
- i Current license
- i Loss Runs

**WARRANTY, AUTHORIZED SIGNATURE AND CONTINUING DUTY TO UPDATE**

The undersigned is an authorized representative of the prospective Named Insured, and acknowledges that the information provided with the Application, including all questionnaires, supplements, attachments, and replies to underwriter inquiries, and applications from other insurance companies which have been submitted to Great American and made part of this application:

1. Will be relied upon by Great American Insurance Group insurers in determining the acceptability of the prospective Named Insured and the premium amount to be charged;
2. Are true, accurate and complete; and
3. Will be considered an integral part of any resultant insurance contract.

The undersigned further agrees that the prospective Named Insured has a continuing duty, through the date of policy inception, to update this Application, including all questionnaires, supplements, attachments and replies to underwriter inquiries.

Signature and printed name and title of authorized representative of applicant and date signed:

Signed: \_\_\_\_\_

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

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

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