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
    - ☐Baseball/Basketball
    - ☐Boxing/ Martial Arts -Contact
    - ☐Boxing/Martial Arts- Non-Contact
    - ☐Climbing/Rappelling/Ropes Course
    - ☐Equine/Horseback Riding
    - ☐Downhill skiing
    - ☐Football-flag
    - ☐Football-tackle
    - ☐Gymnastics
    - ☐Lacrosse/Rugby
    - ☐Off Premises Water Activities
    - ☐Riflery
    - ☐Soccer
    - ☐Track and Field
    - ☐Wrestling
    - ☐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 ☐Sublimit:_________
☐ Claims Made ☐ Included in GL or ☐Sublimit:_________

Total number of clients: _______

		Employees	Volunteers
a.	Is unsupervised contact allowed with clients?	YES ☐ NO ☐	YES ☐ NO ☐
b.	Education verified?	YES ☐ NO ☐	YES ☐ NO ☐
c.	Personal references checked?	YES ☐ NO ☐	YES ☐ NO ☐
d.	Written application required?	YES ☐ NO ☐	YES ☐ NO ☐
e.	State **10-digit fingerprint** criminal record check?	YES ☐ NO ☐	YES ☐ NO ☐
f.	Federal **10-digit fingerprint** criminal record check if in state less than 5 years?	YES ☐ NO ☐	YES ☐ NO ☐
g.	Federal **10-digit fingerprint** criminal record check regardless of time in state?	YES ☐ NO ☐	YES ☐ NO ☐
h.	Are all controls indicated in e, f & g required before client contact?	YES ☐ NO ☐	YES ☐ NO ☐
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)		
Professional Educators:		
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		**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
		Transport Clients		**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
		Home visitation		**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
		Home Meal Delivery		**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
		Other _______		**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐

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?
						☐ Yes ☐ No Retro Date
						☐ Yes ☐ No Retro Date
						☐ Yes ☐ No Retro Date
						☐ Yes ☐ No Retro Date
						☐ Yes ☐ No Retro Date

Please attach a copy of the following with your submission:

- **Most recent state survey**
- **Current license**
- **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: __________________________________