



GREAT AMERICAN INSURANCE COMPANIES

Specialty Human Services Division

CHILDCARE, HEADSTART OR LATCHKEY FACILITIES

QUESTIONNAIRE



Name of organization: _____

Website address (URL): www. _____

Location- copy this sheet if additional space is needed.	Age of Building	# of Childcare Personnel	Age Range of Children	# of Children Licensed for	Average Daily Attendance

1. Are all of your childcare locations licensed by your state's regulatory agency? YES NO
If no, provide details. _____
2. Does your state have regulations YES NO
 - a. Requiring written emergency procedures YES NO
 - b. Requiring written child pick up procedures YES NO
 - c. Mandating maximum staff-to-child ratios YES NO
 - d. Mandating continuing education for employees YES NO
 - e. Have you been cited for failure to meet any regulatory standards? YES NO
If yes, attach copy of citation(s) and inspection report.
3. If facility was built prior to 1980, has premises been inspected and certified lead free? YES NO
4. Do you have an outdoor play area? YES NO
If yes,
 - a. Is outdoor play area fenced? YES NO
 - b. Does the value of your outdoor equipment, including surfacing, exceed \$25,000? YES NO
If yes, value is \$ _____ at _____ (location)
If more than one location, attach a schedule of locations with value at each.
 - c. Was all equipment manufactured after 1992? YES NO
 - d. Does all equipment meet safety standards outlined in the 1991 CPSC Handbook for Public Playground Safety? YES NO
 - e. Was all equipment manufactured by a commercial manufacturer? YES NO
 - f. Was all equipment installed by an insured contractor? YES NO
 - g. Does your state, local government or other regulatory authority require inspection of your playground? YES NO
If yes, how often is inspection performed? _____

ACCIDENT INSURANCE:

5. Does your organization provide accident insurance for children? YES NO
If yes,
 - a. Insurance company name: _____ Policy number: _____
 Policy period: _____ Limits: _____
 - b. Accident insurance applies: to all children is optional, at child's expense

ABUSE COVERAGE:

6. Is abuse coverage desired? YES NO
If yes, complete questions 7-11
7. Type of abuse coverage currently in place:
 None
 Occurrence Included in GL or Sublimit: _____
 Claims Made Included in GL or Sublimit: _____
8. **As respects abuse,**
 a. Have any claims been filed or allegations ever 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
If yes to above, explain: _____

9. Describe any operational procedures you use to control the potential for abuse:

10. Does your facility have written policies that address abuse? YES NO
 a. Are policies reviewed with new employees and volunteers? YES NO
 b. Does policy require all clients be instructed to report possible incidents of abuse? YES NO
 c. Does policy require employees to formally report all incidents of potential abuse to the organization's director or board of directors? YES NO
 d. Does policy require known or suspected abuse incidents be reported to proper authorities? YES NO

11. Provide the following information:

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

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

Explain any "no" responses to question 11: _____

AUTO COVERAGE:

12. Does your organization own or lease vehicles? YES NO
 13. Are all owned or leased vehicles being submitted to us for coverage? YES NO
If yes, attach Acord Auto applications.
14. 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

15. 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? _____
16. Is **non-owned auto liability** coverage desired? YES NO
If yes,
a. Total number of: _____ **employees** _____ **volunteers**
b. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization**.

Type of Usage	Number of Employees with Daily or Weekly Usage	Number of Volunteers with Daily or Weekly Usage	Annual MVR Required?	Proof of Personal Auto Insurance Required on a Renewal Basis?	100/300 or 300 CSL Personal Auto Limits Required?
Errands			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Transport children or others			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

EDUCATOR'S PROFESSIONAL LIABILITY COVERAGE:

17. Is Educator's Professional liability coverage desired? YES NO
If yes, complete questions 18-23

18. List the number of educators who desire primary coverage:

Employees	# of Professionals
Classroom Teachers	
Teacher Aids, Student Teachers, Daycare Workers	
Special Education Teachers	
Guidance Counselors, Vocational Counselors, Psychological Counselors	
School Nurse	
Other professionally trained educators (including administrators)	

19. Are any services provided under contract by teachers and counselors who are not your employees? YES NO
If yes, do you verify the following annually:
a. Certificate of insurance YES NO
b. State license and/or board certificate YES NO
20. Does educational facility have written procedures in place regarding suspension, dismissal and discipline of children? YES NO
If yes, are these procedures reviewed annually with all teachers? YES NO
21. **As respects professional liability:**
a. 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:
b. Has any similar insurance for the entity, present officers or employees ever been cancelled? YES NO
If yes, explain:
22. Prior professional liability insurance carrier: _____
23. Prior professional liability coverage is: Claims Made Occurrence

Completed by: _____ Date completed: _____

