



# United States Liability Insurance Group Commercial/Residential Child Care Centers

## APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

Name of Applicant: \_\_\_\_\_ Mailing Address \_\_\_\_\_  
 DBA: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Insured Contact: \_\_\_\_\_ Location Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Years in Business: \_\_\_\_\_ Date: \_\_\_\_\_  
 Effective Date: \_\_\_\_\_ Coverage to be  Quoted  Bound  
 Expiration Date: \_\_\_\_\_ Sections  GL  Property  WC  EPLI  Umbrella

### Commercial General Liability

1. Form of Business:  Individual  Partnership  Corporation  NonProfit Organization  
 2. Where is the business located?  Commercial building  Private residence  
 3. Limits of Liability Requested:  
 General Liability:  25/25  50/50  100/100  100/300  300/300  300/600  500/500  500/1Mil  1Mil/1Mil  1Mil/2Mil  
 Molestation & Abuse  25/25  50/50  100/100  100/300  300/300  500/500  1Mil/1Mil  
 Nonowned Auto Liability  Hired/Nonowned Auto Liability  100  300  500  1 Mil (not to exceed GL Limit)  
 4. Daily Average Attendance \_\_\_\_\_ (If over 400, submit to Home Office) Number of Employees \_\_\_\_\_  
 5. Do any of the following exposures exist? (If Yes, submit to Home Office)

	Yes	No		Yes	No
Animals/Pets (other than dogs or cats)	<input type="checkbox"/>	<input type="checkbox"/>	Applicant is required to be licensed and is not	<input type="checkbox"/>	<input type="checkbox"/>
24 hr. operations or overnight care?	<input type="checkbox"/>	<input type="checkbox"/>	Has there been a suspension or revocation	<input type="checkbox"/>	<input type="checkbox"/>
Field Trips (over 52 per year)	<input type="checkbox"/>	<input type="checkbox"/>	of certificate or license?	<input type="checkbox"/>	<input type="checkbox"/>
Trampolines or gymnastic equipment	<input type="checkbox"/>	<input type="checkbox"/>	Any alleged or actual incidents regarding	<input type="checkbox"/>	<input type="checkbox"/>
Handicapped or Retarded Children	<input type="checkbox"/>	<input type="checkbox"/>	child molestation or abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Employed or contracted physicians or nurses	<input type="checkbox"/>	<input type="checkbox"/>	Background checks are not done on all	<input type="checkbox"/>	<input type="checkbox"/>
Any losses in past 5 years	<input type="checkbox"/>	<input type="checkbox"/>	potential employees?	<input type="checkbox"/>	<input type="checkbox"/>

6. Does the applicant have a swimming pool? (Must be fenced) .....  Yes  No  
 If Yes, is the pool used by the children? .....  Yes  No  
 7. Does the applicant have a dog or cat? .....  Yes  No  
 (Submit aggressive dogs Breed \_\_\_\_\_)  
 8. Are field trips taken? .....  Yes  No  
 1-12 per year  13-51 per year  
 9. Is an Accident and Health policy for the children in force? .....  Yes  No  
 If Yes, Advise limits  \$2000  \$5000  \$10,000  Other \_\_\_\_\_  
 10. List any additional insureds and their interest: \_\_\_\_\_

### Commercial Property:

1. Are any of the following applicable? (If Yes, decline property) Yes No  
 Property is located within 1/2 mile of coastal waters .....  Yes  No  
 Property is located east of Route 83 on Long Island, NY. ....  Yes  No  
 Property is located in a 1st tier coastal county in MS, AL, TX, LA, NC, SC, GA .....  Yes  No  
 Property is located in Florida .....  Yes  No  
 2. How many property losses in past 3 years \_\_\_\_\_ (Submit if more than one)  
 3. Building Construction \_\_\_\_\_ Protection Class \_\_\_\_\_ Area \_\_\_\_\_ Sq. Ft.  
 4. Coverage Desired: 

	Limit	Valuation	Cause of Loss	Coinsurance
Building	_____	_____	_____	80%
Personal Property	_____	_____	_____	80%
Business Income	_____	_____	_____	80%

 Submit if Total Limits over \$500,000 PC 1-8 or \$200,000 PC 9-10.  
 5. List any loss payees or mortgagees to be added. \_\_\_\_\_

**Employment Practices Liability:**

- Total Number of Employees:  
 \_\_\_\_\_ Full Time + \_\_\_\_\_ (Part Time x .5) = \_\_\_\_\_ Total (If Total Employees exceeds 50, Submit to Home Office)
- Has there been a reduction of employees in last 12 months?  Yes  No \_\_\_\_\_ Percentage (If greater than 10%, Submit to Home Office.)
- Has the Organization closed any facilities, downsized, sold, laid off, or reduced staff, or merged or acquired any company in the past 12 months or does the Organization plan to do so in the next 12 months?  Yes  No (If Yes, submit to Home Office.)
- Within the last 5 years, has an inquiry, complaint or notice of hearing, claim or suit been made (including, but not limited to: Equal Employment Opportunity Commission, State Human Rights Boards, Municipal, State or Federal Regulatory Authorities), against the Organization, or any person proposed for Insurance in the capacity of either Director, Officer, Trustee, Employee or Volunteer of the Organization?  Yes  No (If Yes, Submit to Home Office with details.)
- Is any person proposed for this insurance aware of any fact, circumstance or situation which may result in a claim against the organization or any of its Directors, Trustees, Officers, Employees or Volunteers?  Yes  No (If Yes, Submit to Home Office with details.)

**IMPORTANT**  
 The following must be signed.  
 I, \_\_\_\_\_ (signature) as President or Chairman of the Board of the applicant for insurance, certify that written Anti-Sexual Harassment and Anti-Discrimination Guidelines are already in place or will be implemented within 30 days of the effective date of the policy. These Guidelines will be distributed to all employees.  
 If the insured does not currently have written Anti-Sexual Harassment and Anti-Discrimination Guidelines, The USLI Companies require certification that within 30 days of the effective date of the policy, the insured will establish and distribute written Guidelines to the employees. Sample guidelines will be provided by the company at the insured's request. The USLI Companies will attach an endorsement to the Policy stating that failure to comply with this Certification Agreement shall be grounds for denial for employment claims by the Company.

**Worker's Compensation: (Available in some states)**

- Payroll - Class 8868 or 8869 - Day Care/Nursery School - Professional \_\_\_\_\_
  - Has the applicant had any Workers' Compensation claims in the past 3 years?  Yes  No (If Yes, Submit to Home Office.)
  - Is the class code (8868) payroll greater than \$100,000?  Yes  No (If No, decline.)
  - Is the payroll in excess of \$750,000?  Yes  No (If Yes, Submit to Home Office.)
  - Does the risk have an experience mod?  Yes  No (If Yes, Submit to Home Office.)
  - Prior Carrier(s) & Premiums \_\_\_\_\_
  - Name of Officer(s) to be excluded? \_\_\_\_\_
  - Fed. ID# \_\_\_\_\_
  - If New York, NYS Unemployment Insurance ID (ER) # (If applicable) \_\_\_\_\_  
 If New Jersey, New Jersey Employer Register Number (NJER#) \_\_\_\_\_
- \* If there are additional class codes, an experience mod assigned, or other requested coverages not listed above, please submit on an Accord 130 (Workers' Compensation) Application.*

**Commercial Umbrella:**

**To include Automobile, the underlying Limit must be \$1,000,000, GL Limits must be at least \$500,000.**

- Have there been any Auto losses greater than \$10,000 in the past 5 years?  Yes  No (If Yes, Submit to Home Office.)
- Are there more than 8 vehicles?  Yes  No (If Yes, Submit to Home Office.)
- Is Molestation coverage required?  Yes  No (If Yes, Submit to Home Office.)
- Auto Liability Carrier \_\_\_\_\_ WC or Employers Liability Carrier \_\_\_\_\_  
 Limits \_\_\_\_\_ Premium \_\_\_\_\_ Employers Liability Limits \_\_\_\_\_  
 Vehicles (describe) \_\_\_\_\_

**Fraud Statement:** 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 or 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 violations.

If the applicant is located in the State of New York, the State of New York requires that we have the Name and Address of your (Insured's) Authorized Agent or Broker.  
 Name of Authorized Agent or Broker. \_\_\_\_\_  
 Address. \_\_\_\_\_  
 Mail Completed Application  
 Through Local Agent or Broker to: \_\_\_\_\_

Signature \_\_\_\_\_  
 \_\_\_\_\_ (Chairman of the Board or President)  
 Title \_\_\_\_\_ Date \_\_\_\_\_