



# Quaker Special Risk Day Care Supplemental Application

## APPLICATION

**THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. PLEASE READ YOUR POLICY CAREFULLY.**

1. Applicant: \_\_\_\_\_ Date: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. **Do any of the following exposures exist?**

	Not Eligible:	Eligible:
a. Licensed Capacity _____	<input type="checkbox"/> Over 12	<input type="checkbox"/> 1-12
b. More than one Day Care loss in the last 3 years	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. A Day Care loss larger than \$10,000 in the last 3 years	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Animals or Pets (other than turtle, frog, guinea pig, rabbit, domestic rats, parakeet, canaries, cats and dogs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Dogs of the following breeds: Pit Bulls, Rottweilers, Dobermans, German Shepherds or Bull Mastiffs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. More than 12 field trips per year	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. Any actual or alleged incident regarding child molestation or abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h. Trampolines or gymnastic equipment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. You are required to be licensed and are not	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j. Your license has ever been suspended or revoked	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k. You have a pool on the premises	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l. Handicapped or retarded children	<input type="checkbox"/> Yes	<input type="checkbox"/> No
m. Background checks waived for any employee(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

4. **Limits of Liability Requested.**

Limit Desired (check one)	Coverage G: Professional Liability Limit	Coverage H: Child Molestation or Abuse by your Employees Limit	Coverage I: Reimbursement of Costs where you are accused and Absolved of Molestation or Abuse Limit	Coverage J: Medical Expense Limit	Aggregate Annual Limit (per policy period)
<input type="checkbox"/>	A. \$300,000 per claim	\$100,000 per claim	\$10,000 per claim	\$5,000 any one person	\$600,000
<input type="checkbox"/>	B. \$500,000 per claim	\$100,000 per claim	\$10,000 per claim	\$5,000 any one person	\$1,000,000
<input type="checkbox"/>	C. \$1,000,000 per claim	\$100,000 per claim	\$10,000 per claim	\$5,000 any one person	\$2,000,000
<input type="checkbox"/>	D. \$2,000,000 per claim	\$100,000 per claim	\$10,000 per claim	\$5,000 any one person	\$4,000,000

**Fraud Statement:** Any person who knowingly and with the 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 such violation.

_____	_____
Applicant's Signature	Date
_____	_____
Agent/Broker's Signature	Date

The State of New York requires that we have the Names 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: