

# AMERICAN BANKERS INSURANCE COMPANY OF FLORIDA HANDICAPPED OR THERAPEUTIC RIDING PROGRAM SUPPLEMENTAL QUESTIONNAIRE

(Submit with a completed Commercial Equine Liability application. This is not a binder. An incomplete or unsigned questionnaire is not acceptable).

## YOUR OPERATION

1. Which of the following do you offer?  
 Therapeutic Riding     Hippo-therapy     Psychotherapy     Driving  
 Vaulting     Other (explain)\_\_\_\_\_
2. Provide a brief overview of the operation. \_\_\_\_\_  
\_\_\_\_\_
3. Is there any activity taking place in the ring/arena at the same time as the therapeutic activities?     Yes     No
4. Is this part of any school curriculum, recreational center, or in conjunction with a city or county program?     Yes     No  
If so, describe \_\_\_\_\_
5. Is the program accredited?     Yes     No  
By whom? \_\_\_\_\_  
How many years accredited? \_\_\_\_\_
6. Have you ever contributed to a claim or accident or found negligent in any past equine activity?     Yes     No  
If yes, explain  
\*Submit 3-year hard copy loss runs. Provide an explanation if loss history is not available.
7. Describe in general the disabilities of the riders/participants. \_\_\_\_\_
8. What is the minimum age group accepted for the program? \_\_\_\_\_
9. Do you use side walkers?     Yes     No  
If so, what is the ratio of staff to participants? Staff \_\_\_\_\_ Participants \_\_\_\_\_
10. What is the number of participants at one time? \_\_\_\_\_
11. Do you have written emergency procedures?     Yes     No
12. Describe the training program for the volunteers/trainees. \_\_\_\_\_
13. Do you provide transportation for participants?     Yes     No  
If so, describe \_\_\_\_\_

14. Do you use your own vehicle or employee vehicle?
15. Do you attend off premises shows or demonstrations with participants? Yes  No  
If so, describe \_\_\_\_\_
16. Do you hold Clinics Exhibitions Demonstrations Camps Fundraisers  
 Other Activities for non-students None  
If so, describe \_\_\_\_\_
17. Are you a not-for-profit organization? Yes  No
18. Do you have a web site? Yes  No What is the address? \_\_\_\_\_

**YOUR EXPERIENCE**

19. What is your experience in these operations? \_\_\_\_\_
20. List all personnel including instructors, employees, trainees, volunteers & therapists to date (update annually)  
(Continue on blank paper if needed)

	Name	Experience Level	# Years Employed by Insured	Certified? If so, by whom	Duties	Background Check Completed Y/N

Has any instructor, employee, trainee, volunteer or therapist had any history of violence or criminal conviction? Yes  No

**HORSE EXPERIENCE**

21. List all horses used in the program (updated annually)

Name	Bred/Age	Years in Program	Previous Experience or Training

22. Has any horse ever shown aggressive behavior or caused or contributed to bodily injury or property damage?  Yes  No  
 If yes, explain \_\_\_\_\_

23. Describe the criteria used in selecting horses for the program  
 \_\_\_\_\_

24. Describe the equipment or props used in the program  
 \_\_\_\_\_

25. Are there any horses used in the program that are:  non-owned  leased  rented  
 If so, describe \_\_\_\_\_

**RELEASES/WAIVERS/PROFESSIONAL LIABILITY**

Submit the following if applicable to your operation

- Sample copy of Medical Release forms being used for riders.
- Sample copy of hold harmless/release of liability agreement being used by riders and/or facility if different than your operation.
- Sample copy of volunteer waiver/release of liability.
- Copy of Professional Liability Insurance held by the therapist.
- Copy of the employee/volunteer handbook, rules, guidelines & safety training.

The company reserves the right to decline coverage for omission of any part of this questionnaire. In addition, a loss control survey or inspection may be required/requested. If the company requires that a loss control survey be conducted of your operation, you agree to provide the company representative access to your operation and documents required to complete this survey.

Please provide the name of the party to contact for this inspection/survey.

\_\_\_\_\_  
 Name \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_ Relationship to the Applicant

\_\_\_\_\_  
 Applicant's Name \_\_\_\_\_ Applicant's Signature \_\_\_\_\_ Date

\_\_\_\_\_  
 Agency Name \_\_\_\_\_ Agent Signature (if required) \_\_\_\_\_ Date