

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

