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