



16301 Quorum Dr, Suite 100A, Addison, TX 75001  
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### Renewal Questionnaire

Insured Name: \_\_\_\_\_ Eff Date: \_\_\_\_\_ Website: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/St: \_\_\_\_\_ Zip \_\_\_\_\_  
 Agency Name: \_\_\_\_\_ City/State: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Tel #: \_\_\_\_\_ email: \_\_\_\_\_

**Renewal Coverage:** Property  || General Liability  || Abuse  || Professional  || Auto Liability   
 Auto Phys Damage  || Excess  || D&O  || Accident  || Cyber Liability

**Add'l Coverage requested:** Property  || General Liability  || Abuse  || Professional  Auto Liability   
 Auto Phys Damage  || Excess  || D&O  || Accident  || Cyber Liability

For Profit  || Non-Profit

Year Business Established \_\_\_\_\_ Years Under Present Management \_\_\_\_\_

Indicate all Programs administered by the Insured (check all that apply):

Children's Programs:		Community Services:	
Adoption	<input type="checkbox"/>	Battered Women's Shelter	<input type="checkbox"/>
After School Care	<input type="checkbox"/>	Community Action Programs	<input type="checkbox"/>
Big Brothers/Big Sisters	<input type="checkbox"/>	Community Centers	<input type="checkbox"/>
Boys & Girls Clubs	<input type="checkbox"/>	Counseling	<input type="checkbox"/>
Charter Schools	<input type="checkbox"/>	Family Planning	<input type="checkbox"/>
Children & Teen Shelters	<input type="checkbox"/>	Food bank/Commodity Distribution	<input type="checkbox"/>
Children's Home	<input type="checkbox"/>	Foundations/ Funding Sources	<input type="checkbox"/>
Day Care (Special Needs)	<input type="checkbox"/>	GED Programs	<input type="checkbox"/>
Early Childhood Intervention	<input type="checkbox"/>	Goodwills/ Thrift Stores	<input type="checkbox"/>
Foster Care/ Therapeutic Foster Care	<input type="checkbox"/>	Homeless Shelters	<input type="checkbox"/>
Head Start/Early Head Start	<input type="checkbox"/>	Information/Education/Referral Svcs	<input type="checkbox"/>
Jewish Community Centers	<input type="checkbox"/>	Rape Crisis Centers	<input type="checkbox"/>
Medically Fragile	<input type="checkbox"/>	Transportation Services	<input type="checkbox"/>
Residential Treatment Centers	<input type="checkbox"/>	Vocational/Job Training	<input type="checkbox"/>
Schools - Special Needs	<input type="checkbox"/>	YWCA's	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	Other _____	<input type="checkbox"/>

Senior Programs		Specialty Service Programs	
Adult Day Care	<input type="checkbox"/>	Autistic	<input type="checkbox"/>
Companion Services/Home Maker	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>
Home Health	<input type="checkbox"/>	Developmentally Disabled	<input type="checkbox"/>
Meals On Wheels	<input type="checkbox"/>	Group Homes	<input type="checkbox"/>

Sr. Citizens Centers	<input type="checkbox"/>	Handicapped	<input type="checkbox"/>
Weatherization Program	<input type="checkbox"/>	Mentally Retarded	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	Other _____	<input type="checkbox"/>

**Exposure Update:**

Please describe any changes in your operations (eg; programs administered, services provided, etc.) in the past 12 months:

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Description	Expiring	Renewal	Description	Expiring	Renewal
a) Revenues			g) Camper Days		
b) Clients/Participants			h) Adoptions		
c) Thrift Store Sales			i) Foster Homes/Contacts	____/____	____/____
d) Weatherization/Constrctn Costs or Payroll			j) Property TIV		
e) MOW Food Budget			k) WC Payroll		
f) Avg Daily Volunteers			l) Other		

**C. Professional Liability**

Description of Professional	Employees		Volunteers	Contractors	Interns
	F/T	P/T			
Counselor - Unlicensed					
Dietician/Nutritionist					
Home Health Aide					
Medical Director					
Nurse LPN					
Nurse Practitioner					
Nurse RN					
Pharmacists					
Psychiatrist/Optometrst/Dentist					
Psychologist/Clergy					
Physn Asst/Paramedic/EMT					
Physician					
Residential Manager or Care Provider					
Social Worker/Counselor - Licensed					
Social Worker – Unlicensed					
Teacher/Tutor/Aide/Child Care Worker					
Therapist – Occupational					
Therapist - Physical/Speech/Hearing					
<b>Total</b>					

## D. SUPPLEMENTAL AUTOMOBILE INFORMATION

### Description of Auto Fleet:

Vehicle Type	Expiring	Renewal	# Drivers Exp	# Drivers R/N
Pvt Pass/Pick-up/Mini-van				
Vans > 7 pass				
Bus				
Truck				
Trailer				
Other				

**NOTE:** A driver is an employee whose primary job duties are to operate a motor vehicle for the organization.

1. Are there any drivers under the age of 21 years old? Yes  No
  2. Are all of your vehicles equipped with seat belts? Yes  No 
    - a) Do you have written and strictly enforced guidelines, mandating all passengers are secured in their seat belts? Yes  No
    - b) Would you ever make an exception based on a medical condition? Yes  No
  3. Does insured order/receive/approve MVRs prior to employee driving? Yes  No
  4. Does the insured maintain driver's record files? Yes  No 

Does it include: date of hire\_\_\_\_ dates of training\_\_\_\_ Drug tests\_\_\_\_  
MVR and date ordered and received \_\_\_\_ Reference Checks\_\_\_\_  
Disciplinary actions\_\_\_\_ (check those that apply)
  5. Do you furnish anyone with an auto? Yes  No 
    - a. If yes, are relatives ever allowed to operate an organization's vehicle? Yes  No
  6. Do you have an accident investigation program? Yes  No 
    - a. Do you keep a file on accidents? Yes  No
  7. What number of your employees use their personal auto for your business? \_\_\_\_\_
  8. Is there a vehicle maintenance program? Yes  No 

If yes:

    - a. Are maintenance logs and files reviewed by management? Yes  No
    - b. Do drivers have procedures for reporting, repairing and servicing? Yes  No

If yes - daily , weekly , other \_\_\_\_\_
  9. With respect to any rules or procedures, how do you enforce them to assure compliance?
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10. Does the insured have annual competency-based performance reviews conducted on drivers of the mobility assistance/wheelchair van that includes:
    - a. operation of the lift or ramp system Yes  No
    - b. securing the wheelchair and patient Yes  No
    - c. unloading wheelchair & patient Yes  No
    - d. use of Company communications system Yes  No
  11. Do you obtain written authorization to release driver information from all of your staff upon hiring? Yes  No
  12. Do you obtain MVR's on all drivers? Yes  No 
    - a. If yes, how often? \_\_\_\_\_
    - b. Do you have written criteria on driver acceptability regarding MVR's? Yes  No

14. Do you have a safe driver incentive program? Yes  No   
If yes, describe: \_\_\_\_\_

15. What are your procedures for dealing with driver accidents or violations? \_\_\_\_\_

16. Do all drivers possess the required license for the type of vehicle driven? Yes  No

17. Explain changes to your driver safety program:

### E. Hired & Non-Owned Vehicles

1. Do you hire vehicles? Yes  No   
If yes, what types of vehicles do you hire? \_\_\_\_\_

2. Do you hire from a transportation company? Yes  No   
a. Do you obtain certificates of insurance? Yes  No   
b. What minimum limits do you require? \_\_\_\_\_

3. Annual number of vehicles hired: \_\_\_\_\_ Annual cost of hire: \_\_\_\_\_

4. How many employees/volunteers drive personal vehicles for business use: regularly? \_\_\_\_ occasionally? \_\_\_\_  
a. Do you obtain proof of insurance for anyone driving for business purposes? Yes  No   
b. Do you update these records at least semi-annually? Yes  No   
c. Do you require at least \$100,000 in minimum limits? Yes  No   
d. Do you verify (with a photocopy of the policy or other)? Yes  No

### I have reviewed the existing policy and subsequent endorsements, if any.

- Please QUOTE per expiring policy. Yes  No
- I have reviewed the existing policy and subsequent endorsements, if any.  
Please RENEW per expiring policy. Yes  No
- I have reviewed the existing policy and subsequent endorsements, if any.  
Please QUOTE with the following changes:

\_\_\_\_\_  
\_\_\_\_\_

_____ (Insured's Signature)	Date: _____	_____ (Agent's Signature)	Date: _____
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