



16301 Quorum Dr, Suite 130B, Addison, TX 75001  
800-761-7072 \* Fax 800-224-7145 \* Web address [www.ins-cps.com](http://www.ins-cps.com)

## Pregnancy Center Renewal Questionnaire

Insured Name: \_\_\_\_\_ Eff Date: \_\_\_\_\_

Website: \_\_\_\_\_ Address: \_\_\_\_\_

City/St: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Tel #: \_\_\_\_\_ email: \_\_\_\_\_

### Insurance Agency

Agency Name: \_\_\_\_\_ City/State: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Tel #: \_\_\_\_\_ Email: \_\_\_\_\_

### General Information

1) Total # of Employees \_\_\_\_\_ Total # of Volunteers \_\_\_\_\_

2) Annual Revenue \_\_\_\_\_

3) Professional Services Offered:

- Pregnancy Testing (other than self administered urine)
- Ultrasound/Sonogram to Determine Pregnancy
- Ultrasound – Medical Diagnosis – Specify Diagnosis: \_\_\_\_\_
- Medical Professional Diagnosis – Specify Diagnosis: \_\_\_\_\_
- Adoption Services
- RU486 Reversal / Abortion Reversal
- Other: \_\_\_\_\_
- None of the above- Counseling only (incl materials asst, referral svcs, parenting classes, etc.)

### Property

1) Location: Add  Change  N/A   
Address: \_\_\_\_\_ City/St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupancy/Use (office, retail store, home... etc.) \_\_\_\_\_

A) Year built: \_\_\_\_\_ # of Stories: \_\_\_\_\_ Construction Type: \_\_\_\_\_

B) Sq. Ft. \_\_\_\_\_ Burglar Alarm? Yes  No  Sprinkler System? Yes  No

C) Do you own the building? Yes  No

i) Building Value: \$ \_\_\_\_\_ N/A  (if you do not own the building, this is only applicable if you are required to insure the building for the building owner)

ii) Contents Value: \$ \_\_\_\_\_ (include on premise sonograms)

iii) Sonogram Value: \$ \_\_\_\_\_ (only sonograms that leave the premises)

**Maternity/Baby Store** N/A

1) Annual Sales: \_\_\_\_\_

**Hired/Non-Owned Auto** N/A

1) Do you hire vehicles? Yes  No  If yes, what types? \_\_\_\_\_

a) Annual # of vehicles hired: \_\_\_\_\_ Annual cost of hire \_\_\_\_\_

2) How many employees/volunteers driver personal vehicles for business use:

a) Regularly: \_\_\_\_\_ Occasionally: \_\_\_\_\_

**Residential Facilities** N/A

2) # of Pregnant Women housed: \_\_\_\_\_

3) Number of beds available: \_\_\_\_\_ Number of Units: \_\_\_\_\_

**Professional Liability** N/A

<u>Title</u>	<u>Employees</u>		<u>Volunteers</u>
	<u>F/T</u>	<u>P/T</u>	
Peer Counselors			
Medical Directors			
Nurse LPN			
Nurse Practitioner			
Nurse RN			
Physician Asst/Paramedic/EMT			
Physicians			
<b>TOTAL</b>			

**Changes**

1) Please describe any changes in your operations (eg. Programs administered, services provided, etc.) in the past 12 months: \_\_\_\_\_

2) I have reviewed the expiring policy and subsequent endorsements, if any.

Please QUOTE per expiring policy: Yes  No

3) I have reviewed the expiring policy and subsequent endorsements, if any.

Please QUOTE with the following changes: \_\_\_\_\_

**Losses**

1) Have you had any losses in the past 12 months? Yes  No

If yes, please describe \_\_\_\_\_

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