



**Care Providers**  
Insurance Services

19111 N. Dallas Parkway, Suite 250, Dallas, TX 75287  
800-761-7072 \* Fax 800-224-7145 \* Web address [www.ins-cps.com](http://www.ins-cps.com)

## School 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: \_\_\_\_\_

For Profit  // Non-Profit

### General Information

1) Type of School: Private  Charter  Annual Revenue \_\_\_\_\_

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

3) # of Students: Pre K-8 \_\_\_\_\_ 9-12<sup>th</sup> \_\_\_\_\_ Post High \_\_\_\_\_

If more than 1 location, please attach a breakdown per location.

4) Day Care: # of children \_\_\_\_\_ N/A

5) Afterschool program that enrolls children not attending the school? Yes  No

a) If yes: # of non-school children: \_\_\_\_\_

6) Type of security for schools: Guards  Security Cameras  Other  \_\_\_\_\_

A) If guards are utilized: Are the guards armed? Yes  No

i) If armed, are they: Contracted Services  Volunteer  Employed

If contracted, are certificates obtained from the security service? Yes  No

If yes, please provide the name of the insurance carrier \_\_\_\_\_

Please attach a copy of the certificate of insurance.

### 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

1) Annual # of students by grade: Pre-K \_\_\_\_\_ K-5 \_\_\_\_\_ 6-8 \_\_\_\_\_ 9-12 \_\_\_\_\_

2) Annual # of teachers: \_\_\_\_\_

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

**Camps**

N/A

1) Is the camp held on premises? Yes  No

2) Day Camp: a) Number of days \_\_\_\_\_ Number of Campers \_\_\_\_\_

3) Does the camp provide overnight services? Yes  No

a) Number of days \_\_\_\_\_ Number of Campers \_\_\_\_\_

**Athletics**

1) Are sports programs available for students? Yes  No  If yes, please complete below.

Football (tackle)  Lacrosse  Rugby  Hockey  Gymnastics  Soccer

Rock Climbing  Competitive Cheerleading  Equestrian  Skiing

a. Are signed parental releases including an assumption of risk statement obtained for all sports participants before they are allowed to participate? Yes  No

b. Is a sports physical required for all students? Yes  No

c. Is the property safety equipment provided & required for all sports? Yes  No

d. Are written safety guidelines in place for all sports? Yes  No

e. Is student/sports accident coverage obtained for all students? Yes  No

2) Concussion Protocol:

a. Does your organization have a written concussion policy that is in compliance with current state legislation? Yes  No

b. Do you distribute the written policy to coaches, parents and players and require parent's acknowledgement that they have received and reviewed? Yes  No

c. Does your concussion policy require a medical doctor's release prior to the child returning to play? Yes  No

d. Does your concussion policy mandate that all coaches participate in concussion training at least once every two years? Yes  No

e. Does your organization utilize baseline training? Yes  No

3) Have you added any new sports programs in the past 12 months? Yes  No

If yes, please list: \_\_\_\_\_

**Professional Liability    N/A**

<u>Title</u>	<u>Employees</u>		<u>Vols</u>	<u>Contractor</u>	<u>Interns</u>
	<u>F/T</u>	<u>P/T</u>			
Teacher/Aide/Child Care Worker					
Principal/Assistant Principal					
Sports Coach or Trainer					
Tutor (paid)					
Counselor - Unlicensed					
Dietician/Nutritionist					
Nurse LPN or RN					
Psychiatrist/Psychologist/Clergy					
Social Worker					
Therapist – Physical/Speech/Hearing					
Physician					
<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  If no, Please QUOTE with the following changes: \_\_\_\_\_  
 \_\_\_\_\_

**Losses**

1) Have you had any losses in the past 12 months?                      Yes                       No   
 If yes, please describe \_\_\_\_\_  
 \_\_\_\_\_

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