

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act, as amended, that you have a right to purchase insurance coverage for losses resulting from acts of terrorism, as defined in Section 102(1) of the Act: The term “act of terrorism” means any act that is certified by the Secretary of the Treasury – in consultation with the Secretary of Homeland Security, and the Attorney General of the United States – to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 and 80% BEGINNING ON JANUARY 1, 2020, OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A \$100 BILLION CAP THAT LIMITS U. S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS’ LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS \$100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED \$100 BILLION, YOUR COVERAGE MAY BE REDUCED.

Acceptance or Rejection of Terrorism Insurance Coverage

- I hereby elect to purchase Terrorism coverage for a prospective premium of _____ % (\$ _____) of the policy premium subject to a \$100 minimum.

- I hereby decline to purchase Terrorism coverage. I understand that I will have no coverage for losses resulting from acts of terrorism.

_____ Policyholder/Applicant’s Signature	_____ Account Name	
_____ Print Name	_____ Date	_____ Policy Number

Western World Insurance Company – Tudor Insurance Company – Stratford Insurance Company
300 Kimball Drive, Suite 500, Parsippany, New Jersey 07054
Telephone: (201) 847-8600

THE ASSOCIATION OF CHILD CARE PROFESSIONALS, LTD. PROGRAM RENEWAL APPLICATION

*****All questions must be completed*****

Applicant's Name: _____	Requested Effective Date: _____
Business Name: _____	
Mailing Address: _____	
<i>P.O. Box or Street</i>	<i>City</i>
<i>County</i>	<i>State</i>
<i>Zip</i>	
Street Address (if different than mailing address above): _____	
Phone Number: _____	Email Address: _____

SECTION I - GENERAL INFORMATION

PLEASE COMPLETE EVERY ITEM

1. Do you live at the above Address (i.e. are you operating an In-home Daycare)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is there any other business (i.e. other than your daycare business) operating at the above Address? If yes, please describe that other business: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is your Local/State In-home Daycare Provider License, Certification or Registration current?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. Number of Children you are Licensed, Certified or Registered to care _____	
B. Average number of Children you care for on a daily _____	
C. Has your License, Certification or Registration ever been revoked or suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____	
D. Has a Citation or Warning ever been issued against you or your In-home Daycare Provider operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____	
E. Has anyone residing in your household ever been convicted of a felony or been involved in any Sexual Molestation investigation or prosecution?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____	

SECTION II - OPERATIONS

PLEASE COMPLETE EVERY ITEM

1. Do you ever give over-the-counter medication to any of the Children in your care? If yes, answer A-B.	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. Before dispensing the medication, do you receive written authorization from the Parent/Guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Is medication dispensed in accordance with the Parent's/Guardian's, Physician's or Manufacturer's written instructions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you ever give prescription medication to any of the Children in your care? If yes, answer A-B.	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. Before dispensing the medication, do you receive written authorization from the Parent/Guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Is medication dispensed in accordance with the Parent's/Guardian's or Physician's written instructions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you provide care for Infants? If yes, answer A.	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. Are Infants placed in cribs (i.e. not in beds) during nap time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you care for any special needs Children? If yes, answer A-B.	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. Describe the nature of their special needs: _____	
B. Is specialized training required to address their needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you provide any Overnight Care? If yes, answer A.	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. How frequently is Overnight Care provided? _____	
6. Do any pets live at the above Address? If yes, answer A-B.	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. Please describe all pets (if a dog, list the breed): _____	
B. Are all of your pets' immunizations up-to-date?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION III - FACILITY

PLEASE COMPLETE EVERY ITEM

1. Within the last year, has any new Playground Equipment been added at the above Address? If yes, answer	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. Describe all Playground Equipment: _____	
2. Do you own a Trampoline or any other jumping devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is there a Swimming Pool, with depths more than 18", located at the above Address? If yes, answer A-B.	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. Is the Swimming Pool enclosed by a fence with a self-closing and self-locking gate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Provide your current Homeowners or Renters Insurance Policy Information: Carrier Name: _____ Policy Number: _____ Policy Effective Date: _____	

SECTION IV - RATING

Your Policy Premium will include Comprehensive General Liability at the requested Limits. Subject to the Terms, Conditions and Exclusions stated in your Policy, this includes coverage for Bodily Injury, Property Damage, Personal and Advertising Injury and Daycare Service Professional Liability. In addition, the following coverages will be included: Medical Payments (i.e. with a \$5,000 Limit), Sexual Molestation Insurance (i.e. with a \$100,000 Each Claim Limit and a \$300,000 Aggregate Limit) and Animal Injury Liability (i.e. with a \$25,000 Each Claim Limit and a \$50,000 Aggregate Limit). **Use the chart below to determine your annual Policy Premium.**

1. **Select your Average Daily Attendance.**
2. **Select the desired Comprehensive General Liability Each Occurrence and General Aggregate Limits.**
3. **Select the applicable Premium Level.**

Level 1: Applies to all accounts, other than those described below as Level 2 accounts.

Level 2: All accounts located in the **District of Columbia** or in any of the following **Cities or Counties:**

State	City	County
California	Los Angeles or San Francisco	Orange
Florida		Broward or Dade
Illinois		Cook
New York		Bronx, Kings (AKA Brooklyn), Nassau, New York (AKA Manhattan), Putnam, Queens, Richmond (AKA Staten Island), Rockland, Suffolk or
Pennsylvania	Philadelphia	
Texas	Dallas or Houston	

Average Daily Attendance	Comprehensive General Liability Each Occurrence and General Aggregate Limits							
	<input type="checkbox"/> \$100,000/\$300,000		<input type="checkbox"/> \$300,000/\$600,000		<input type="checkbox"/> \$500,000/\$1,000,000		<input type="checkbox"/> \$1,000,000/\$2,000,000	
	Level 1	Level 2	Level 1	Level 2	Level 1	Level 2	Level 1	Level 2
1 - 6 Children	\$246	\$369	\$309	\$464	\$350	\$525	\$447	\$671
7 Children	\$259	\$389	\$323	\$485	\$373	\$560	\$472	\$708
8 Children	\$286	\$429	\$358	\$537	\$408	\$612	\$513	\$770
9 Children	\$337	\$506	\$421	\$632	\$474	\$711	\$611	\$917
10 Children	\$382	\$573	\$477	\$716	\$548	\$822	\$651	\$977
11 Children	\$421	\$632	\$526	\$789	\$583	\$875	\$733	\$1,100
12 Children	\$449	\$674	\$561	\$842	\$657	\$986	\$814	\$1,221
13 Children	\$494	\$741	\$617	\$926	\$693	\$1,040	\$879	\$1,319
14 Children	\$534	\$801	\$667	\$1,001	\$729	\$1,094	\$936	\$1,404

Policy Premium (i.e. Excluding Additional Insured and Terrorism Coverage): \$ _____

***Additional Insured Premium Charge:** \$ _____

*Include a \$25 Additional Premium Charge for each required Additional Insured (i.e. other than for Landlords, Funding Sources or Food Program Groups). **List their Names, Addresses and Insurable Interests below:**

Membership Fee: \$ 40

Total Amount Due: \$ _____

ANY POLICY QUOTED MAY BE SUBJECT TO A MINIMUM POLICY PREMIUM.

Applicant's Signature

APPLICANT: THIS APPLICATION, INCLUDING ALL ATTACHMENTS, BECOMES PART OF YOUR POLICY (IF ISSUED). I UNDERSTAND THAT THIS APPLICATION FOR INSURANCE AND ANY POLICY ISSUED AS A RESULT OF THE APPROVAL OF THIS APPLICATION WILL **ONLY** PROVIDE INSURANCE FOR IN-HOME DAYCARE OPERATIONS. I FURTHER UNDERSTAND THAT NO COVERAGE WILL BE PROVIDED FOR ANY OTHER BUSINESS, OPERATIONS OR SERVICES UNLESS THEY ARE SPECIFICALLY ADDED TO ANY POLICY ISSUED FOR AN ADDITIONAL PREMIUM.

FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO IS GUILTY OF INSURANCE FRAUD. THIS IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (FOR NEW YORK INSURED: AN ACT OF INSURANCE FRAUD SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)

Applicant's Signature:		Date:	
Applicant's Name:		Applicant's Title:	