

Therapeutic Riding Supplemental Application

Applicant: _____ Producer: _____ Number: _____
Quote #: _____ Requested Effective Date: _____

All Therapeutic Rides must utilize Safety Helmets to be eligible for coverage consideration.
All Therapeutic Rides must be given in an enclosed area to be eligible for coverage consideration. Rope or Wire enclosures are not permitted.

Do you operate your Therapeutic Riding operations under another name? Yes No
If yes, please provide: _____

Do you offer Therapeutic Riding in cooperation with other organizations? Yes No
If yes, please provide name of organization and explain: _____

Years experience providing Therapeutic Riding: _____
Please describe any certifications/accreditations/licenses your operation has pertaining to Therapeutic Riding: _____

Please indicate types of activities you provide along with the percentage of your operation they represent:

<input type="checkbox"/> Recreational Riding for Individuals with Disabilities _____ %	<input type="checkbox"/> Therapeutic Driving _____ %	<input type="checkbox"/> Competitions for Riders with Disabilities _____ %
<input type="checkbox"/> Therapeutic Vaulting _____ %	<input type="checkbox"/> Hippotherapy _____ %	<input type="checkbox"/> Equine Assisted Therapy _____ %
<input type="checkbox"/> Equine Facilitated Therapy _____ %	<input type="checkbox"/> Equine Assisted Psychotherapy _____ %	
<input type="checkbox"/> Other (Please explain and provide percentage): _____		

Total Therapeutic Rides given annually: _____	Average number of weekly Therapeutic Rides: _____
Maximum number of horses used at one time: _____	Total number of instructors at one time: _____
Total number of Volunteers at one time: _____	Total number of Volunteers per each rider: _____

Do you offer Therapeutic Rides year-round? Yes No
If no, please provide dates of operation: _____

Does your operation have outside Therapists/Instructors present during Therapeutic Rides? Yes No
If yes, please explain their certifications and activities: _____

Please indicate the types of disabilities individuals have which your operation provides Therapeutic Rides to:

<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Autism	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Brain Injuries
<input type="checkbox"/> Spinal Cord Injuries	<input type="checkbox"/> Cardiovascular accident	<input type="checkbox"/> Stroke	<input type="checkbox"/> Amputations	<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Deafness	<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Emotional Disabilities
<input type="checkbox"/> Attention Deficit Disorder							
<input type="checkbox"/> Other (Please explain): _____							

Do you have medical permission forms on record for all riders? Yes No

Are Safety Helmets mandatory? Yes No
Other safety procedures (explain): _____

Do you ever fasten (tie) riders to any part of the saddle or horse? Yes No
If yes, please explain: _____

Are all Therapeutic Rides conducted in an enclosed area? Yes No
Please describe enclosure and fencing: _____

Please describe any Non-Equestrian activities associated with your Therapeutic Riding activities: _____

Please list any fundraising, promotional activities, or other events open to the public:
Public event date(s): _____ Description of event: _____ Location of event: _____
Description of event activities: _____

REMEMBER: EXPOSURES NOT DECLARED ARE NOT COVERED.

Average charge per Therapeutic Ride (if any): \$ _____ Annual Gross Revenue from Therapeutic Riding: \$ _____

I/We understand that this is a policy of indemnity and will only provide a defense up to the point where the insurance company tenders the coverage limit for settlement. I/We understand and agree that any misstatement of warranty or fact on this application shall be considered a violation of coverage afforded under any policy issued on the basis of this application. I/We understand and agree that this application shall form a part of any policy issued. I/We understand that this application is not a binder. I/We understand that the Company requires that I/we obtain additional insured certificates of insurance from independent contractors for coverage to remain in effect. I/We understand any policy issued will not provide Worker's Compensation Coverage and/or any Employer's Liability coverage.

(Must be signed and dated)

Applicant's Signature: _____

Print name: _____ Date: _____