



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)

### Renewal Questionnaire

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

**Renewal Coverage:** Workers' Comp  || Property  || General Liability  || Abuse  || Professional   
 Auto Liability  || Auto Phys Damage  || Umbrella  || D&O  || AD&D

**Add'l Coverage requested:** Workers' Comp  || Property  || General Liability  || Abuse  || Professional   
 Auto Liability  || Auto Phys Damage  || Umbrella  || D&O  || AD&D

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 Svs	<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 Palsey	<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) Vehicles			g) Camper Days		
b) Clients/Participants			h) Adoptions		
c) Thrift Store Sales			i) Foster Homes/Contacts	____/____	____/____
d) Weatherization/Construction 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/Optometrlist/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>					

- 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:**

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