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:

- ☐ Recreational Riding for Individuals with Disabilities_____%
- ☐ Therapeutic Driving_____%
- ☐ Competitions for Riders with Disabilities_____%
- ☐ Therapeutic Vaulting_____%
- ☐ Hippotherapy_____%
- ☐ Equine Assisted Therapy_____%
- ☐ Equine Facilitated Therapy_____%
- ☐ Equine Assisted Psychotherapy_____%
- ☐ 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:

☐ Muscular Dystrophy ☐ Cerebral Palsy ☐ Down Syndrome ☐ Mental Retardation ☐ Autism ☐ Multiple Sclerosis ☐ Spina Bifida ☐ Brain Injuries
☐ Spinal Cord Injuries ☐ Cardiovascular accident ☐ Stroke ☐ Amputations ☐ Visual Impairment ☐ Deafness ☐ Learning Disabilities ☐ Emotional Disabilities
☐ Attention Deficit Disorder ☐ 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:*__________