

**AMERICAN BANKERS INSURANCE COMPANY OF FLORIDA  
HANDICAPPED OR THERAPEUTIC RIDING PROGRAM  
SUPPLEMENTAL QUESTIONNAIRE**

(Submit with a completed Commercial Equine Liability application. This is not a binder. An incomplete or unsigned questionnaire is not acceptable).

**YOUR OPERATION**

1. Which of the following do you offer?  
 Therapeutic Riding       Hippo-therapy       Psychotherapy       Driving  
 Vaulting       Other (explain)
2. Provide a brief overview of the operation.
3. Is there any activity taking place in the ring/arena at the same time as the therapeutic activities?       Yes       No
4. Is this part of any school curriculum, recreational center, or in conjunction with a city or county program?       Yes       No  
If so, describe
5. Is the program accredited?       Yes       No  
By whom?  
How many years accredited?
6. Have you ever contributed to a claim or accident or found negligent in any past equine activity?       Yes       No  
If yes, explain  
\*Submit 3-year hard copy loss runs. Provide an explanation if loss history is not available.
7. Describe in general the disabilities of the riders/participants.
8. What is the minimum age group accepted for the program?
9. Do you use side walkers?       Yes       No  
If so, what is the ratio of staff to participants?      Staff \_\_\_\_\_ Participants
10. What is the number of participants at one time?
11. Do you have written emergency procedures?       Yes       No
12. Describe the training program for the volunteers/trainees.
13. Do you provide transportation for participants?       Yes       No  
If so, describe
14. Do you use your  own vehicle or  employee vehicle?

15. Do you attend off premises shows or demonstrations with participants?  Yes  No  
If so, describe
16. Do you hold  Clinics  Exhibitions  Demonstrations  Camps  Fundraisers  
 Other Activities for non-students  None  
If so, describe
17. Are you a not-for-profit organization?  Yes  No
18. Do you have a web site?  Yes  No What is the address?

**YOUR EXPERIENCE**

19. What is your experience in these operations?
20. List all personnel including instructors, employees, trainees, volunteers & therapists to date (update annually)  
(Continue on blank paper if needed)

Name	Experience Level	# Years Employed by Insured	Certified? If so, by whom	Duties	Background Check Completed Y/N

Has any instructor, employee, trainee, volunteer or therapist had any history of violence or criminal conviction?  Yes  No

**HORSE EXPERIENCE**

21. List all horses used in the program (updated annually)

Name	Bred/Age	Years in Program	Previous Experience or Training

