



**United States Liability Insurance Group**  
**Nighttime Child Care**



P.O. Box 768 Hendersonville, TN 37077  
 800-768-7475 Fax (615) 264-3980  
 www.bsrrins.com

**SUPPLEMENTAL APPLICATION**

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

Name of Applicant \_\_\_\_\_ Date: \_\_\_\_\_

**Acceptable    Prohibited**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1) Are the children in the facility less than 10 hours?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2) Is the facility licensed for nighttime care?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3) Is the facility locked and/or alarmed after 7 PM?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4) Are there at least two staff members on duty at all times?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5) Are all children 12 years old or younger?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6) Are all staff members over age 21?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7) Are all staff members required to be awake?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8) Are the children regularly enrolled at the center?           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9) Number of Children cared for from 9:00pm until 6:00am: _____ |                              |                             |

**Fraud Statement:** 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, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violations.

If the applicant is located in the State of New York, the State of New York requires that we have the Name and Address of your (Insured's) Authorized Agent or Broker.

Name of Authorized Agent or Broker. \_\_\_\_\_

Address. \_\_\_\_\_

Mail Completed Application  
 Through Local Agent or Broker to: \_\_\_\_\_

Signature \_\_\_\_\_  
 (Owner or Officer of Corporation)

Title \_\_\_\_\_ Date \_\_\_\_\_