Therapeutic Riding Supplemental Application

Applicant:_____ Producer:_____

Quote #:_____ Requested Effective Date:_____

McNamara Company
1330 Hwy 96 St. Paul, MN 55110
Phone 651-426-0607 Fax 651-426-5790
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www.BuyHorseInsurance.com

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:*_____