



Care Providers
Insurance Services

19111 N. Dallas Parkway, Suite 250, Dallas, TX 75287
800-620-9314 * Fax 800-224-7145

Pregnancy Center Renewal Application

Insured Name: _____ Eff Date: _____

Website: _____ Address: _____

City/St: _____ Zip: _____

Contact Person: _____ Tel #: _____ email: _____

Insurance Agency	
Agency Name: _____	City/State: _____
Contact Person: _____	Tel #: _____ Email: _____

General Information

1) Total # of Employees _____ Total # of Volunteers _____

2) Annual Revenue _____

3) Professional Services Offered:

- Pregnancy Testing (other than self administered urine)
- Ultrasound/Sonogram to Determine Pregnancy
- Ultrasound – Medical Diagnosis – Specify Diagnosis: _____
- Medical Professional Diagnosis – Specify Diagnosis: _____
- Adoption Services
- RU486 Reversal / Abortion Reversal
- Other: _____
- None of the above- Counseling only (incl materials asst, referral svcs, parenting classes, etc.)

Property

1) Location: Add Change N/A
Address: _____ City/St: _____ Zip: _____
Occupancy/Use (office, retail store, home... etc.) _____

A) Year built: _____ # of Stories: _____ Construction Type: _____

B) Sq. Ft. _____ Burglar Alarm? Yes No Sprinkler System? Yes No

C) Do you own the building? Yes No

i) Building Value: \$ _____ N/A (if you do not own the building, this is only applicable if you are required to insure the building for the building owner)

ii) Contents Value: \$ _____ (include on premise sonograms)

iii) Sonogram Value: \$ _____ (only sonograms that leave the premises)

Maternity/Baby Store/Thrift Store N/A

1) Annual Sales: _____

Hired/Non-Owned Auto N/A

1) Do you hire vehicles? Yes No If yes, what types? _____

a) Annual # of vehicles hired: _____ Annual cost of hire _____

2) How many employees/volunteers driver personal vehicles for business use:

a) Regularly: _____ Occasionally: _____

Residential Facilities N/A

2) # of Pregnant Women housed: _____

3) Number of beds available: _____ Number of Units: _____

Professional Liability N/A

<u>Title</u>	<u>Employees</u>		<u>Volunteers</u>
	<u>F/T</u>	<u>P/T</u>	
Peer Counselors			
Medical Directors			
Nurse LPN			
Nurse Practitioner			
Nurse RN			
Sonographer			
Physician Asst/Paramedic/EMT			
Physicians(other than Medical Director)			
TOTAL			

Changes

1) Please describe any changes in your operations (eg. Programs administered, services provided, etc.) in the past 12 months: _____

2) I have reviewed the expiring policy and subsequent endorsements, if any.

Please QUOTE per expiring policy: Yes No

3) I have reviewed the expiring policy and subsequent endorsements, if any.

Please QUOTE with the following changes: _____

Losses

1) Have you had any losses in the past 12 months? Yes No

If yes, please describe _____

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