SCHATZ INSURANCE

WEST BEND®

FITNESS CENTER INSURANCE QUESTIONNAIRE

APPLICANT INFORMATION:

Named Insured: _____

Mailing Address: _____

E-mail: _____

Web Address: _____

Main Contact Person: _____ Cell Phone: _____ Email: _____

Business Entity: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other (specify): _____

REQUIREMENTS FOR QUOTE:

- 3-5 Year Loss History
- All Waivers
- Brochures and Advertising Literature
- Vehicle Schedule – Year, Make, Model
- Property Schedule – Year Built, Construction, Replacement Cost, Content Limit for each location
- Equipment Schedule – Year, Make, Model, and Value

PREMISES INFORMATION:

Location #	Building #	Street, City, County, State, ZIP

Prior Insurance Carrier:

Policy Premium:

Expiration Date:

GENERAL INFORMATION:

1. Has any policy or coverage been declined, cancelled, or non-renewed in the past 3 years?
2. Any Past Losses or claims? Choose One:
3. Have you even filed for bankruptcy or have any outstanding tax liens (i.e. Property tax, sales tax, unemployment tax, etc.)? Choose One:

   If yes, please explain:
4. Prior Insurance Carrier:
5. Hours of operation:

   If open 24 hours, what safeguards are in place to protect property and members at night? _____

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6. Annual Sales (include membership fees):
7. # of Employees: _____ Full Time _____Part Time
8. How long have you been in business?
9. Square footage of facility?
10. Number of Club members?
11. Do you have non slip surfaces in wet areas? Choose One:
12. Do you require members to sign a waiver? (if yes please provide a copy) Choose One:
13. Does the facility contain showers? Choose One:
14. Do you have tanning beds? Choose One:
15. Who services/repairs the equipment?
    a. Do you keep maintenance logs? Choose One:
16. Please describe the services do you offer and the sales for each? (child care, personal training, group classes, counseling, physical therapy, massage therapist, Courts, Climbing walls, etc.)

_____
_____
_____
_____

STAFF

Please indicate the number of personnel for the following classifications (Full Time and Part Time):

Office Staff:
Personal Trainers:
Fitness Instructors:
Yoga Instructors:
Dancing Instructors:
Nutrition Counselors:
Physical Therapists:
Massage Therapists:
Child Care:
Lifeguards:
Other:

Do you have any volunteers? _____Full Time _____ Part Time

MEDICAL ASSISTANCE

1. Is there an accident policy for members? Choose One:
2. Are first aid kits available? Choose One:
3. Do you have AEDs available? Choose One:
4. Do you have Emergency Oxygen available? Choose One:

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5. Is any staff certified in CPR or First Aid? Choose One:
   If yes, please describe _____
6. Do you have a written medical emergency plan? (if yes, please provide) Choose One:

SEXUAL ABUSE

(Must be completed if located in Illinois)

1. Do you perform a criminal background investigation including sexual abuse or child abuse related offenses on prospective employees and volunteers? Choose One:
2. Do you verify employment related references? Choose One:
3. Do you conduct personal interviews? Choose One:
4. Do you discuss the following at staff orientation?
   a. Child/sexual abuse Choose One:
   b. How to recognize the signs of abuse Choose One:
   c. What to do if a client/child reports someone molested him/her Choose One:
5. Do you have a supervision plan that monitors staff in day to day relationships with clients? Choose One:
6. Do you have knowledge of any incident which could result in an allegation of sexual abuse? Choose One:
   a. If yes, please explain: _____
   _____
7. Has there ever been an allegation of sexual abuse? Choose One:
   a. If yes, please explain: _____
   _____

LEAGUES

1. Number of Teams: _____
2. Total number of games player per season (including playoffs, tournaments, etc.) _____
3. Does the league provide umpires, referees, or other officials? Choose One:
   a. If yes, please explain: _____
4. Does the league provide training for managers, coaches, or officials? Choose One:
   a. If yes, please explain: _____

UMBRELLA

1. Do you need a commercial Umbrella? Choose One:
2. What limit? (1 million, 2 million, 3, million, 4 million, 5 million, etc.)
   _____

WORKERS COMPENSATION

1. Do you need workers compensation? Choose One:

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2. Please describe the type of work performed by employees?

   _____

   _____

   _____

3. Annual payroll for employees?

COMMERCIAL AUTO

1. Does the business own any automobiles titled in the business name? Choose One:
2. Is insurance needed for owned vehicles? Choose One:

Year	Vehicle Make	Vehicle Model	VIN Number

3. Deductibles?
4. Do any employees, owners, or officers, driver personally owned vehicles in the course of their work? Choose One:

The information I have provided is true and accurate to the best of my knowledge. I have not willfully concealed or misrepresented any material fact(s) or information. I understand completion of this questionnaire does not compel the company to provide coverage.

_____ _____

Applicants Signature Date

_____

Agents Signature

For questions please contact Patrick Schatz: 847-356-1520 x117. pschatz@schatzins.com

SUBMIT