



APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE

NOITCE: THIS IS A PROPOSAL FOR A CLAIMS-MADE AND REPORTED POLICY. THE POLICY FOR WHICH THIS PROPOSAL IS MADE IS LIMITED TO LIABILITY FOR WRONGFUL ACTS FOR WHICH CLAIMS ARE FIRST MADE WHILE THE POLICY IS IN FORCE AND WHICH ARE REPORTED TO THE INSURER NO LATER THAN SIXTY (60) DAYS AFTER THE TERMINATION OF THE POLICY.

THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSS, INCLUDING JUDGEMENT OR SETTLEMENT AMOUNTS, SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE AND OTHER CLAIM EXPENSES. FURTHER NOTE THAT AMOUNTS INCURRED FOR LEGAL DEFENSE AND OTHER CLAIM EXPENSES SHALL BE APLIED AGAINST THE APPLICABLE RETENTION AMOUNT.

THE POLICY DOES NOT PROVIDE FOR ANY DUTY OR OBLIGATION ON THE PART OF THE INSURER TO DEFEND THE INSURED PERSONS AND THE COMPANY.

Instructions:

- A. Answer all questions. If the answer to any question is NONE, please state NONE.
 - B. If the space to answer any question fully is insufficient, attach a separate sheet.
 - C. The application must be signed and dated by the owner, partner, or officer and by a human resources or personnel officer.
 - D. **PLEASE READ CAREFULLY THE STATEMENT AT THE END OF THIS APPLICATION.**
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GENERAL INFORMATION

1. Applicant's name and address:
(Please include the names of all companies and subsidiaries which are to be covered if the policy is issued.)

2. Name, title, and phone number of person to contact:

3. Describe the applicant's operations and give the number of locations by state:

4. Coverage desired:

Limit of Liability: _____

Proposed Effective Date: _____

Deductible: _____

Retroactive Date: _____

5. Do you currently carry Employment Practices Liability Insurance?

Yes No

If yes, please provide details as to the Insurer, the limits of liability, deductibles, retroactive date and premium.

6. Do you currently carry Directors and Officers liability insurance?

Yes No

If yes, please provide the name of the carrier and also indicate the limits of liability?

7. Employees:

a. Please provide the number of full-time and part-time employees in the following geographical locations:

	full-time	part-time
California and / or Texas	_____	_____
Michigan, Montana, Missouri, Ohio, and / or New Jersey	_____	_____
All other states	_____	_____
Total	_____	_____

b. Indicate below by their salary ranges the number of employees:

Salary ranges	full-time	part-time
\$ 30,000 or less per year	_____	_____
\$ 30,001 - \$ 50,000 per year	_____	_____
\$ 50,001 - \$100,000 per year	_____	_____
Over \$100,000 per year	_____	_____
Total	_____	_____

c. For each of the last four (4) years, state your annual percentage turnover rate of employees.

_____ % _____ % _____ % _____ %

d. For each of the last four (4) years, indicate the number of officers and other employees that have been involuntarily terminated.

_____ _____ _____ _____

e. Do any employees have written contracts of employment?

Yes No

If yes, how many? _____ Please attach a specimen contract.

LOSS HISTORY

8. a. Regardless of whether or not such loss may have been covered by any insurance policy, have you had or do you presently have any employment related claims including, but not limited to, complaints, charges, grievances, arbitrations, litigation, or administrative agency proceeding (federal, state, or local) concerning employment termination, discrimination, sexual harassment, wage and hour violations, and unfair labor practices?

Yes No If yes, for each of the past five (5) years, please provide the following information:

Year	Number of Claims	Damage or Settlement Amount	Legal Expense Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

b. Have you ever been involved in any claim or proceeding of the type described in a. above, for which you or your insurer has paid or reserved in excess of \$ 10,000 (including amounts paid or reserved for the defense of the claim or proceeding)? Yes No

If yes, please complete and attach the **EMPLOYMENT PRACTICES LIABILITY APPLICATION CLAIM SUPPLEMENT** for each such claim or proceeding. If there were no claims or proceedings paid or reserved in excess of \$ 10,000 state NONE. _____

c. Are you aware of actual or alleged wrongful employment practices or other facts incidents, or circumstances that may result in claims being made against you? Yes No

For purposes of this question, wrongful employment practices include employment terminations, constructive discharge from employment, discrimination for whatever reason, and sexual harassment.

If yes, please explain on a separate sheet.

IT IS UNDERSTOOD AND AGREED THAT AS TO ANY WRONGFUL EMPLOYMENT PRACTICE CLAIM, WRONGFUL EMPLOYMENT PRACTICE, FACT, INCIDENT, OR CIRCUMSTANCE THAT ARE OR SHOULD BE DISCLOSED IN RESPONSE TO QUESTIONS 8. a., b., OR c. ABOVE, ANY CLAIM ARISING THEREFORM IS EXCLUDED FROM COVERAGE UNDER THE POLICY FOR WHICH THIS APPLICATION IS MADE.

HUMAN RESOURCES DEPARTMENT

9. a. Do you have a Human Resources or Personnel Department? Yes No
How many employees are in this department? _____

If no, please provide details on the handling of this function on a separate page.

b. Do you have a formal out-placement program which assists terminated or laid-off employees in finding other jobs? Yes No

If yes, please describe the program. _____

c. Provide the name and address of any firm performing employee review, disciplinary, or employee hiring services, and furnish a description of the services provided.

d. Do you use a written employment application form for your employment applicants? Yes No

e. Do you make use of tests to screen employment applicants? Yes No

If yes, please provide details.

- f. Do you have an employment handbook? Yes No
If yes, is the handbook distributed to all of your employees? Yes No
- g. Do you have a formal orientation program for all new employees? Yes No
If yes, please provide details.

- h. Do you conduct regular written performance evaluations of all your employees? Yes No
- i. Do you have an affirmative action plan? Yes No
If yes, please provide a copy.
- k. Do you have formal policies or procedures regarding:
- 1) sexual harassment? Yes No
 - 2) the handling of employee complaints of discrimination or sexual harassment? Yes No
 - 3) AIDS or assisting employees with life threatening or communicable diseases? Yes No
 - 4) accommodating the disabled in accordance with the Americans With Disabilities Act? Yes No
 - 5) the Family and Medical Leave Act of 1993? Yes No

If you answered yes to any of the items in this question 9., please provide copies of all such policies, forms, and handbooks together with information regarding the distribution of such policies, forms, and handbooks to your employees, e.g. notices on bulletin boards, annual distribution to all employees, etc.

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10. Do you require that all employment terminations be reviewed prior to discharge by:
- 1) the Human Resources Department? Yes No
 - 2) the Legal Department? Yes No
 - 3) outside counsel? Yes No

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11. Do you anticipate any full or partial plant, facility, branch, or office closing or layoffs within the next twenty-four (24) months? Yes No
If yes, please provide details on a separate page(s).

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12. Do you anticipate any lay-offs or reduction in force (RIF) within the next twenty-four (24) months? Yes No
If yes, please provide details on a separate page(s).

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13. Do you have written procedures for disciplining employees? Yes No

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14. Do you have written procedures for terminating employees? Yes No
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CORPORATE HISTORY

15. a. Has your business name changed? Yes No

If yes, list all former names on a separate sheet.

- b. 1) Have you acquired any new subsidiaries or other business organizations in the last five (5) years? Yes No
- 2) If yes, did the purchase include the assumption of liabilities? Yes No
- 3) If yes, does the information provided in response to Question 8. include these acquired subsidiaries or organizations? Yes No
- 4) With respect to acquired subsidiaries or organizations, were any employees or officers terminated or do you plan in the next eighteen (18) months to terminate any employees or officers? Yes No
- c. 1) Have you sold any subsidiaries or other business organizations in the last five (5) years? Yes No
- 2) Did the sale include the transfer of liabilities to the purchaser? Yes No

CLAIMS HANDLING PROCEDURES

16. a. Who in the insured's organization will be responsible for the reporting of claims to the insurer under any policy that may be issued pursuant to this application?

Name: _____ Title: _____

Address: _____

Telephone Number (include area code): _____

- b. Who in the insured's organization will be responsible for handling claims in conjunction with the insurer under any policy that may be issued pursuant to this application?

Name: _____ Title: _____

Address: _____

Telephone Number (include area code): _____

- c. With respect to claims, incidents, etc.:

1) Do you have a written procedure for obtaining information: Yes No

If yes, please provide a copy.

2) Have you made supervisory personnel aware in writing of your desire for prompt notice? Yes No

If yes, please provide a copy.

THIS APPLICATION WILL NOT BE PROCESSED IF THE FOLLOWING APPLICABLE INFORMATION IS INCLUDED. FAILURE TO INCLUDE THE APPLICABLE INFORMATION FOR ANY COMPANY TO BE COVERED BY THIS INSURANCE WILL DELAY THE ISSUANCE OF A QUOTE UNTIL THE INFORMATION IS RECEIVED OR WILL RESULT IN A QUOTE EXCLUDING THE COMPANY(IES) FOR WHICH THE INFORMATION HAS NOT BEEN RECEIVED.

Indicate attachments by an (X):

a. Financial Statements

e. Employment Application Form(s)

- | | |
|---|--|
| b. <input type="checkbox"/> Securities and Exchange Commission Form 10-K | f. <input type="checkbox"/> Supervisory Manual(s) |
| c. <input type="checkbox"/> Employee Handbook, manual, and work rules | g. <input type="checkbox"/> Employee Performance Form(s) |
| d. <input type="checkbox"/> Employee disciplinary, termination and out-placement procedures | h. <input type="checkbox"/> EEO-1 Report |

THE UNDERSIGNED AUTHORIZED APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE. THE "EFFECTIVE DATE" IS THE DATE THE COVERAGE IS BOUND OR THE FIRST DAY OF THE CURRENT POLICY PERIOD, WHICHEVER IS LATER.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO KENTUCKY APPLICANTS: Warning: Any person who knowingly, and with intent to defraud any insurance company or any person files an application for insurance 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.

NOTICE TO MINNESOTA APPLICANTS: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or any person files an application for insurance containing any 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 (\$5,000) and the stated value for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 subjects the person to criminal and civil penalties.

NOTE: BOTH SIGNATURE LINES MUST BE COMPLETED.

_____	_____	_____
Date	Applicant's Authorized Signature of a Principal, Partner, or Officer	Title

	Please Print Name	

_____	_____	_____
Date	Applicant's Authorized Signature of individual in charge of the Human Resources or Personnel Department	Title

	Please Print Name	

NAME OF BROKER _____

NAME OF AGENCY _____

ADDRESS _____

SIGNED _____

PLEASE SUBMIT THIS APPLICATION AND APPROPRIATE MATERIALS TO:

APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE

SUPPLEMENTAL CLAIM FORM

This form is to be completed by each applicant who has been involved in any claim or suit or who is aware of any incident which may give rise to a claim. Please complete a separate sheet for each claim or incident and answer all questions fully. A principal of the firm must sign and date this sheet in addition to the application.

1) NAME OF FIRM: _____

2) NAME OF INDIVIDUALS OF FIRM INVOLVED IN CLAIMS: _____

3) NAME OF CLAIMANT (PLINTIFF): _____

4) DATE OF ALLEGED ERROR: _____

5) DATE CLAIM MADE: _____

6) NAME OF INSURER CLAIM REPORTED TO (IF APPLICABLE): _____

7) PRESENT STATUS OF CLAIMS: PENDING CLOSED IN SUIT

8) IF CLOSED, TOTAL DAMAGES PAID: _____ TOTAL EXPENSES PAID: _____

9) IF PENDING, AMOUNT ASKED IN SUMMONS: _____

CLAIMANT'S SETTLEMENT DEMAND: _____

DEFENDANT'S SETTLEMENT OFFER: _____

INSURER'S LOSS RESERVE: _____

EXPENSES PAID TO DATE: _____

10) DETAILED DESCRIPTION OF CLAIM AND EVENTS: (PROVIDE CLAIMANT'S ALLEGATIONS AND OUR FIRM'S RESPONSE)

11) EXPLAIN WHAT ACTIONS HAVE BEEN TAKEN TO PREVENT A RECURRENCE OR SIMILAR CLAIM:

I UNERSTAND THE INFORMATION SUBMITTED HEREIN BECOMES A PART OF MY EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION AND IS SUBJECT TO THE SAME ONDITIONS.

APPLICANT'S SIGNATURE

DATE