



PROPOSAL FOR PRIVATE CHOICE
INSURANCE POLICY
FLORIDA

Insurer: _____

NOTICE: 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. PLEASE READ AND REVIEW THE POLICY CAREFULLY.

THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSS, INCLUDING JUDGMENT OR SETTLEMENT AMOUNTS, SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE AND OTHER CLAIMS EXPENSES. FURTHER NOTE THAT AMOUNTS INCURRED FOR LEGAL DEFENSE AND OTHER CLAIMS EXPENSES SHALL BE APPLIED 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.

1. GENERAL INFORMATION:

- a) Name of Company
b) Address
c) Nature of Business and number of locations by state
d) State of Incorporation and Date thereof:

2. STOCK OWNERSHIP:

- a) Total number of common shares outstanding
b) Total number of common shareholders
c) Total number of common shares held directly or beneficially by Directors and Officers
d) Describe fully any other securities convertible to common shares
e) Have shares been publicly traded within the last 3 years? Yes No
If Yes, please provide the details.

f) Give names and percent owned of any shareholders who hold, directly or beneficially, 5% or more of the common shares outstanding:

Table with 3 columns: Owner, Type of Security, % Owned

6. 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 | _____ | _____ |
| All other states | _____ | _____ |
| Total | _____ | _____ |

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

_____ % _____ % _____ % _____ %

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

_____ _____ _____ _____

7. HUMAN RESOURCES DEPARTMENT:

a) Do you have a Human Resources or Personnel Department? ___ Yes ___ No

b) How many employees are in this department? _____

If No, who handles the Human Resources function? _____

c) Do you use a written employment application form for your employment application? ___ Yes ___ No

d) Do you have an employee handbook? ___ Yes ___ No
If Yes, is the handbook distributed to all of your employees? ___ Yes ___ No

e) Do you conduct regular written performance evaluations of all your employees? ___ Yes ___ No

f) 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) accommodating the disabled in accordance with the Americans with Disabilities Act? ___ Yes ___ No
4) the Family and Medical Leave Act of 1993? ___ Yes ___ No

g) 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

h) 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).

i) Have you had in the last 24 months or do you expect in the next 12 months any layoffs or reductions in force (RIF)? ___ Yes ___ No

If Yes, please provide details on a separate page(s).

j) If questions (h) or (i) are Yes, 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. _____

If you answered Yes to any of the items in Question 7, 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.

8. LOSS HISTORY:

a) Regardless of whether 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 proceedings (federal, state, or local) concerning employment termination, discrimination, sexual harassment, wage and hour violations, or 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 \$25,000 (including amounts paid or reserved for the defense of the claim or proceeding)? Yes No

If Yes, please complete and attach the CLAIM SUPPLEMENT for each such claim or proceeding.

c) Has the Company, or anyone for whom insurance is intended, been involved in the following within the last 5 years?

- 1) any civil or criminal action or administrative proceeding alleging a violation of any federal or state anti-trust, copyright, patent or securities law or regulation? Yes No
- 2) any representative actions, class actions or derivative suits? Yes No
- 3) any government regulatory or administrative proceedings? Yes No

d) Is there any material litigation currently pending against the Company or any of its Directors or Officers? Yes No

e) Are there any pending claims or demands against the Company or anyone for whom this insurance is intended which may fall within the scope of coverage afforded by any similar insurance presently or previously in effect or currently proposed? Yes No

If Yes, provide complete details. _____

f) Has anyone for whom this insurance is intended given notice under the provisions of Yes No

any other previous or current similar insurance policy of any claims or facts or circumstances which may give rise to a claim being made against the Company and/or any Director and/or Officer?

If Yes, provide complete details. _____

IT IS UNDERSTOOD AND AGREED THAT IF ANY SUCH CLAIMS EXIST, OR ANY SUCH FACTS OR CIRCUMSTANCES EXIST WHICH COULD GIVE RISE TO A CLAIM, THEN THOSE CLAIMS AND ANY OTHER CLAIMS ARISING FROM SUCH FACTS OR CIRCUMSTANCES ARE EXCLUDED FROM THE PROPOSED INSURANCE.

9. PRIOR KNOWLEDGE: (RENEWAL APPLICANTS: Question 9. need not be answered).

Does anyone for whom this insurance is intended have any knowledge or information of any act, error, omission, fact, circumstance or wrongful employment practice which may give rise to a claim which may fall within the scope of the proposed insurance? Yes No

If Yes, provide complete details.

IT IS UNDERSTOOD AND AGREED THAT IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM ARISING THEREFROM IS EXCLUDED FROM THIS PROPOSED INSURANCE.

10. MATERIALS REQUESTED:

As an attachment to this Proposal, please include the following (where applicable):

- Complete list of all Directors and Officers to include their name, position, term of office, and affiliation with any other outside organizations.
- Most recent Annual Report and most recent filings with the SEC (Forms 10-K, 10-Q, 8-K, etc.)
- Latest CPA letter to management and any written response thereto.
- Latest available interim financial statements.
- The notice to shareholders and proxy statement for both the last and next scheduled annual meeting.
- Employee handbook, manual and work rules.
- Employment Application Forms.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS PROPOSAL CHANGES BETWEEN THE DATE OF THIS PROPOSAL 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 PROPOSAL DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS PROPOSAL 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 PROPOSAL ARE HEREBY INCORPORATED BY REFERENCE INTO THIS PROPOSAL AND MADE A PART HEREOF.

FRAUD WARNING

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.

A POLICY CANNOT BE ISSUED UNLESS THE PROPOSAL IS PROPERLY SIGNED BY TWO INDIVIDUALS AND DATED. IF THE CHAIRMAN OF THE BOARD AND PRESIDENT ARE THE SAME INDIVIDUAL, PLEASE HAVE THE PROPOSAL SIGNED BY THE CHIEF FINANCIAL OFFICER, CHIEF OPERATING OFFICER OR GENERAL COUNSEL IN LIEU OF THE PRESIDENT.

DATE _____

SIGNATURE _____

TITLE _____

DATE _____

SIGNATURE _____

TITLE _____

AGENT NAME _____

AGENT LICENSE NUMBER _____

PLEASE SUBMIT THIS PROPOSAL AND APPROPRIATE MATERIALS TO:

Hartford Financial Products
2 Park Avenue
New York, N.Y. 10016

PRIVATE CHOICE INSURANCE PROPOSAL

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 separate sheets 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 (PLAINTIFF):** _____
 - 4) **DATE OF ALLEGED ERROR:** _____
 - 5) **DATE CLAIM MADE:** _____
 - 6) **NAME OF INSURER CLAIM REPORTED TO (IF APPLICABLE):** _____
 - 7) **PRESENT STATUS OF CLAIM:** PENDING CLOSED IN SUIT
 - 8) **IF CLOSED, TOTAL SETTLEMENT 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 YOUR FIRM'S RESPONSE)**

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

I UNDERSTAND THE INFORMATION SUBMITTED HEREIN BECOMES A PART OF MY PROPOSAL FOR PRIVATE CHOICE INSURANCE AND IS SUBJECT TO THE SAME CONDITIONS.

APPLICANT'S SIGNATURE

DATE