

Employment Practices Liability Insurance
APPLICATION AND UNDERWRITING
INFORMATION FORM

IMPORTANT: **THIS APPLICATION AND UNDERWRITING INFORMATION FORM IS FOR A CLAIMS MADE POLICY.**

NOTICE TO PROPOSED INSURED

Please read this entire application and underwriting information form ("application") carefully and answer all questions that are applicable.

Throughout this application, the words "you" and "your" refer to the prospective Insured identified in Item 1.A.i. of the application and in Item 1 of the policy Declarations if a policy is issued. The words "we," "us" and "our" refer to the Insurers that are underwriting the policy, if any policy is issued.

This policy is offered on a claims made basis covering Claims and Potential Claims that are first made during the POLICY PERIOD or any applicable EXTENDED REPORTING PERIOD for incidents of Discrimination, Harassment or Inappropriate Employment Conduct which take place after the RETROACTIVE DATE shown in Item 8 of the Declarations. All COVERAGE under the policy ceases upon the termination of the policy, except for the Limited Reporting Period of thirty (30) days starting from the end of the POLICY PERIOD unless the insured purchases an Extended Reporting Period after the end of the POLICY PERIOD. Once the Limited and Extended Reporting Period, if one is purchased, expire, there is no more COVERAGE under this policy.

We may have previously issued a quotation for insurance based on preliminary information provided by you or your broker. That quotation may change or be withdrawn based on the information provided in this application. Please understand that even if information was previously provided to us in connection with the preliminary quotation, full and complete information must be provided in this application, as this application supersedes and replaces any information provided earlier.

We will materially rely upon this application in establishing the terms, conditions and pricing of the policy, if we issue a policy. It is your responsibility to ensure that the information contained in this application is complete and accurate BEFORE you sign it. This application will become part of your policy should one be issued and the date of your signature will be recorded in the policy Declarations.

Only a Principal, Officer, or the individual in charge of Human Resources in your company is eligible to sign and initial this application. The signature must be dated within 30 days prior to your requested policy inception date (60 days for renewals). Signing this application does not bind you to accept or bind us to offer any Insurance described herein.

I. GENERAL INFORMATION

A. i. Name and address of Primary Insured:

Please enter your zip code here:

ii. All other Offices or Locations (attach a separate sheet if Needed):

Name	Address	Zip code	No. E'ees

iii. Subsidiaries to be Insured and Locations (attach a separate sheet if Needed):

Name	Address	Zip code	No. E'ees

B. Risk Manager, Human Resources Director or other person to be contacted regarding this insurance:

C. Nature of Business and Principal Industry:

D. COVERAGE LIMIT and SELF INSURED RETENTION Requested (US\$):

Each Insured Event Limit/Total Aggregate Limit

\$500,000/\$500,000
\$1,000,000/\$1,000,000
\$2,000,000/\$2,000,000
\$3,000,000/\$3,000,000
Other \$

SELF INSURED RETENTION

\$5,000
\$10,000
\$15,000
\$20,000
\$25,000
\$50,000
Other \$

E. i. Please provide Total Annual Receipts or Sales for you and all subsidiaries to be insured for the last completed financial year, and your estimate for the current and next financial year:

Past Year	US\$
Current Year	US\$
Next Year	US\$

ii. If the Annual Receipts or Sales have increased or decreased, or are expected to increase or decrease, by more than 20% in consecutive years, please provide a detailed explanation of the reasons for such variance. (Attach additional pages if necessary.)

II. CORPORATE HISTORY

- F. i. How long have you been in business: Years
 ii. How long under current management: Years
- YES NO
- iii. Have the majority of your present officers and senior management been employed by you for more than two years?
- If "No," please identify all officers and senior management, and indicate the length of employment for each. (Attach additional pages if necessary.)
- G. Do any of the following apply to you or to any Subsidiary to be insured? For any "Yes" response, please provide full details. (Attach additional pages if necessary.)
- i. Any plant, facility, branch or office closures, consolidations or layoffs affecting more than 20% of your total workforce or more than 50 **Employees** (whichever is less) in the last 18 months?
 - ii. Any Officers or **Employees** already terminated or laid off as a result of any merged, acquired or taken over company(ies) in the last 18 months?
 - iii. Any company(ies) that you plan to, or are in the process of purchasing, merging with or taking over, that will result in Officers and **Employees** of either your company or the acquired, merged or taken over company being terminated or laid off?
 - iv. Any company(ies), organizations or individuals which are not owned by you or under your control (such as subcontractors, consultants, suppliers, etc.) for which, by operation of law or by contract or other means, you have already or will in the future assume some or all of their employment liabilities or responsibilities?

III. PREVIOUS AND OTHER INSURANCE

- H. i. Have you previously purchased employment practices liability insurance?
 If "Yes," please state for each prior policy:

INSURER	POLICY PERIOD	POLICY LIMITS/ DEDUCTIBLE or SELF INSURED RETENTION

- ii. Has any previous employment practices liability insurer ever cancelled or non-renewed your coverage?
 If "Yes," please state the reasons given by such insurer for the cancellation or non-renewal. (Attach additional pages if necessary.)
- iii. Has any insurer ever declined or rejected your application for employment practices liability insurance?
 If "Yes," please state the reasons, if any, given by such insurer for the declination.

IV. LOSS HISTORY

i. You must advise us of all **Claims** that have been made against you or any Subsidiary to be insured during the past 5 years (irrespective of whether or not covered by insurance) and all incidents, facts or circumstances known to any of your Officers, Directors, **Managers, Or Supervisory Employees** where an applicant for employment, **Employee** or third party has either written about or verbally mentioned making a **Claim** for **Inappropriate Employment Conduct, Harassment or Discrimination**.

YES NO

i. Have any **Claims** (including lawsuits or threatened lawsuits) been made against you or any subsidiary to be insured, by any **Employee** (including Officers) or applicant for employment, during the past 5 years, for alleged **Inappropriate Employment Conduct, Harassment or Discrimination**?

If "Yes," how many such **Claims** have been made? _____

For each **Claim**, please describe in detail such **Claim**, including whether such **Claim** is still pending, the total incurred for defense of such **Claim**, and the total paid for settlement of judgment rendered. (Attach additional pages if necessary.)

ii. Have any **Claims** (including lawsuits or threatened lawsuits) been made against you or any Subsidiary to be insured, by any third party, during the past 5 years, for alleged **Harassment or Discrimination**?

If "Yes," how many such **Claims** have been made?

For each **Claim**, please describe in detail such **Claim**, including whether such **Claim** is still pending, the total incurred for defense of such **Claim**, and the total paid for settlement of judgment rendered. (Attach additional pages if necessary.)

iii. Have any complaints or charges been filed against you or any subsidiary to be insured with any regulatory agency (including but not limited to the National Labor Relations Board, the Equal Employment Opportunity Commission or any similar Federal or State agency) during the past 5 years?

If "Yes," please describe in detail each such complaint or charge, the findings made by the regulatory agency and the total incurred for defense of the complaint or charge. (Attach additional pages if necessary.)

iv. Is any Officer, Director, manager or **Supervisory Employee** employed by you or any subsidiary to be insured aware of any facts, circumstances, disagreements or incidents which might result in a **Claim** against you or any such subsidiary, by any **Employee** (including Officers) or applicant for employment, for **Inappropriate Employment Conduct, Harassment or Discrimination**?

If "Yes," please describe all such facts, circumstances, disagreements or incidents. (Attach additional pages if necessary.)

v. Is any Officer, Director, manager or **Supervisory Employee** employed by you or any subsidiary to be insured aware of any facts, circumstances, disagreements or incidents which might result in a **Claim** against you or any such subsidiary, by any third party for **Harassment or Discrimination**?

If "Yes," please describe all such facts, circumstances, disagreements or incidents. (Attach additional pages if necessary.)

V. EMPLOYEES AND SPECIAL GROUPS

J. i. Number of **Employees**, including Partners, Directors and Officers, for all locations and Subsidiaries to be insured:

Full Time Part Time Seasonal Temporary Leased

ii. If you have any "Seasonal" or "Temporary" **Employees**, please provide an explanation of the work duties and average length of employment for each group. (Attach additional pages if necessary.)

YES NO

iii. Do any of your **Employees** belong to a union or do you have collective bargaining agreements impacting any of your **Employees**?

If "Yes," please identify the union and the number of **Employees** affected, and please attach copies of all collective bargaining agreements.

UNION	NUMBER OF EMPLOYEES	COLLECTIVE BARGAINING AGREEMENT? (Yes/No)

YES NO

iv. Are there any groups of persons who are not directly employed by you or any subsidiary to be insured (such as **Employees** of subsidiaries not to be insured, suppliers, consultants, wholly-controlled entities, etc.) for which you may legally be deemed an "employer" or for which you may have liability, either by operation of law or by contract or other means.

If "Yes," please explain. (Attach additional pages if necessary.) NOTE: **Claims** made by any such persons who are not identified in this application will not be subject to coverage under the policy, if any.

K. Salary Ranges and Terminated Employees

i. For your current **Employees**, please state:

SALARY RANGE (Annual)	FULL TIME EMPLOYEES	PART TIME EMPLOYEES
\$0 - \$30,000		
\$30,001 - \$50,000		
\$50,001 - \$100,000		
\$100,001 - \$250,000		
\$250,001 and greater		
TOTAL		

- ii. For full-time **Employees** who have left during the 2 years preceding this application, please state:

Past Year	Employees	Officers
Terminated		
Left Voluntarily		
TOTAL		

Prior Year	Employees	Officers
Terminated		
Left Voluntarily		
TOTAL		

VI. HUMAN RESOURCES

- L. Please indicate whether the following are true for you and all subsidiaries to be insured. For any "No" response, please provide full details. (Attach additional pages if necessary.)

YES NO

- i. Written employment agreements are made with all **Employees** and officers
- ii. All **Employees** and officers are employed on an "at will" basis
- iii. All new job applicants complete a written employment application form
- iv. All new **Employees** are given an induction or appropriate training upon joining
- v. There is an Employee Handbook which is provided to all **Employees**
- vi. All **Employees** are required to acknowledge in writing receipt of the Employee Handbook
- vii. The Employee Handbook has been reviewed by your attorney or Human Resources Department. If yes when was it last reviewed?
- viii. Personnel files, with attendance records for vacation, sick leave and personal days recorded, are maintained for each **Employee**
- ix. All **Employees**, whether full time or part time, receive at least annual written performance evaluations, and those evaluations are kept in each **Employee's** personnel file
- x. **Anti-Harassment** and **anti-Discrimination** policies and procedures are implemented and are included in the Employee Handbook

Yes No

- xi All Equal Employment Opportunity Commission policies and procedures that apply to your company are implemented and followed by all Officers, Managers and **Supervisory Employees**
 - xii All Officer or **Employee** disciplinary actions or terminations are reviewed and approved, before implementation, by either your labor attorney or your Human Resources Department
 - xiii There is a written grievance and complaints procedure specified in the Employee Handbook which is made known and available to all **Employees**
 - xiv There is a written Health and Safety procedure in place which is made known and available to all **Employees**
- M.
- i. Do you currently have, or are you planning to implement within the next year, written arbitration procedures for dissatisfied **Employees** and Officers
 - ii. Do you have a full-time Human Resources Department or a retained attorney who has labor law expertise?

VII. THIRD PARTY EXPOSURE

- N. Please indicate whether the following are true for you and all subsidiaries to be insured. For any "**No**" response, please provide full details. (Attach additional pages if necessary.)
- i. There are written procedures for handling complaints by Third Parties of **Discrimination** or **Harassment**
 - ii. There are records of all complaints by third parties of **Discrimination** or **Harassment**, and these records are kept for a minimum of two years
 - iii. All public facilities on your premises or for which you are responsible have access for the disabled in accordance with the Americans with Disabilities Act and related laws
 - iv. Customer/client relations training is provided to all your **Employees** who deal with customers and clients on a regular basis

**APPLICATION SUPPLEMENT
(NOT APPLICABLE IN HAWAII, MAINE, NEBRASKA, NEW YORK, VIRGINIA
VERMONT OR OKLAHOMA)**

One of the following **FRAUD STATEMENTS** may apply in your state. If applicable, please read the statement carefully, place an X in the block next to the statement that applies to your state, sign and date at the bottom.

APPLICABLE IN THE STATE OF COLORADO

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 with the department of Regulatory Agencies.

APPLICABLE IN THE STATE OF OHIO

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.

APPLICABLE IN THE STATE OF OREGON

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 may be guilty of a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

APPLICABLE IN ALL OTHER STATES

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.

APPLICANT'S SIGNATURE

DATE

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 **Potential Claim** which may give rise to a **Claim**. Please complete a separate sheet for each **Claim** or **Potential Claim** and answer all questions fully. This form must be signed and dated in addition to the application.

Name of Applicant:

Name of individuals of firm involved in **Claim/Potential Claim**:

Name of claimant (plaintiff):

Date of alleged **Claim/Potential Claim**:

Date Applicant became aware of **Claim/Potential Claim**:

Name of the Insurer to whom the **Claim** was reported (if applicable):

Present status of **Claim**: Pending Closed In suit **Potential Claim Only**

Claimant's settlement demand \$

Defendant's settlement offer \$

Loss paid \$

Loss reserve \$

Expenses paid \$

Expenses reserved \$

Detailed description of **Claim/Potential Claim** and events: (Provide claimant's allegation and applicant's response):

What actions have been taken to prevent a recurrence or similar **Claim**?

I understand information submitted herein becomes a part of my employment practices liability insurance application and is subject to the same terms and conditions.

Date Applicant's Signature _____

Supplementary Page

Please reference the number of the question to which these responses apply.