

# Employment Practices Liability Application

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY THE CHAIRPERSON OR PRESIDENT OF APPLICANT.  
**THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. PLEASE READ YOUR POLICY CAREFULLY.**

1. Name of Organization: \_\_\_\_\_  
 Primary Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Website Address: \_\_\_\_\_

2. Person to receive all notices on behalf of the Insured: \_\_\_\_\_  
 Title: \_\_\_\_\_ Email Address: \_\_\_\_\_

3. Do you have more than one location?  Yes  No  
 If yes, attach a list of all locations, including the address and the number of employees at each site.

4. Is the applicant a subsidiary of another Organization?  Yes  No  
 Name of Parent: \_\_\_\_\_ Location: \_\_\_\_\_

5. Description of Operations: \_\_\_\_\_

6. Total number of employees.	Current <u>12 months</u>	Prior <u>12 months</u>	Anticipated next 12 months <u>(If operating less than 3 years)</u>
Full Time:	_____	_____	_____
Part Time:	_____	_____	_____
Temporary/Seasonal:	_____	_____	_____
Independent Contractors:	_____	_____	_____
Leased:	_____	_____	_____

7. How many employees have been involuntarily terminated in the past 12 months? \_\_\_\_\_ 24 months? \_\_\_\_\_

8. Number of years in operation? \_\_\_\_\_  
 If less than 3 years, provide description of experience of owners and senior management.

9. Has the Organization closed, downsized, laid off, reduced staff, sold, merged or acquired any company in the past 12 months?  Yes  No  
 Does the organization anticipate doing so in the next 12 months?  Yes  No  
 If yes to either, please attach details.

10. Percentage of employees with total compensation including salaries, bonuses and commissions over \$75,000 \_\_\_\_\_%

11. Does the Organization currently carry Employment Practices Liability Insurance?  Yes  No  
 If yes, provide the following:

Name of Insurer	Limits	Policy Period	Deductible/Retention	Premium	Retroactive date
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12. Does the Organization want any subsidiary(s) covered?  Yes  No  
 If yes, provide name(s), nature of operation, number of employees and percentage of ownership the organization has in the subsidiary.

13. Within the last 5 years has any employment related, or third party discrimination, or third party sexual harassment: inquiry, complaint, notice of hearing, claim or suit been made against the Organization or any person proposed for Insurance in the capacity of either Director, Officer or Employee of the Organization?  Yes  No  
**If "Yes," please complete a United States Liability Insurance Group claim supplement for each claim.**
14. Is any person proposed for this Insurance aware of any fact, circumstance or situation which may result in an employment claim or third party discrimination or third party sexual harassment claim against the Organization or any of its Directors, Officers or Employees?  Yes  No  
**If "Yes," please complete a United States Liability Insurance Group claim supplement for each claim.**
15. Do you have an Email/Internet Policy currently in place?  Yes  No  
 If no, are you willing to implement one? (Sample can be provided by the Company)  Yes  No  
**A premium credit will be applied for having, or agreeing to implement, an Email/Internet Policy.**  
 Please submit a copy of current or newly implemented policy within 21 days after the inception date of this insurance.

**Mandatory Written Employment Policies.** Please identify policies Applicant has in place:

- Anti-Harassment Policy  Yes  No  
 Anti-Discrimination Policy  Yes  No

**Please forward copies of the policies identified above along with this signed and dated application.** If you do not have these written policies in place, the Company will provide you with sample policies at the time of binding this insurance.

As a condition precedent to issuance of the Policy for Insurance, the Applicant agrees:

- 1) to implement and distribute to each employee the Mandatory Anti-Harassment and Anti-Discrimination Policies which are currently not in place as soon as possible, but no later than 21 days after the inception date of this insurance. Failure of the Company to receive these policies within 21 days after the inception date of this insurance will result in rescission of the binder for this insurance.
- 2) to adopt and distribute to each employee all changes required by the Company to the Applicant's Written Policies, as soon as possible, but no later than 21 days after receipt of notice of the changes required by the Company.

**Recommended Written Employment Policies.** Please identify policies Applicant has in place:

- Employment Application  Yes  No  
 If applicant has an Employment Application, a copy must be forwarded for review by the Company as soon as possible, but no later than 21 days after the inception date of this insurance. Failure of the Company to receive this application within 21 days after the inception date of this insurance will result in rescission of the binder for this insurance.
- Employee Handbook  Yes  No  
 Contains Employment-At-Will Statement?  Yes  No  
 Contains statement that Handbook is not a contract of employment?  Yes  No

**Arizona, Pennsylvania and Oregon Fraud Statement:** 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 may be subject to a civil penalty (and a criminal penalty if in Pennsylvania)

**Utah, Connecticut, Ohio Fraud Statement:** Any person who, with intent to defraud or knowing that he/she 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.

**Maine, Tennessee and Virginia Fraud Statement:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Virginia Notice:** You have an option to purchase a separate limit of liability for the extension period, policy common conditions VII. If you do not elect this option, the limit of liability for the extension period shall be part of the and not in addition to the limit specified in the declarations. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

**Nevada Fraud Statement:** 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.

**Kentucky Fraud Statement:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning and fact material thereto commits a fraudulent insurance act, which is a crime.

**Florida Fraud Statement:** 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.

**Fraud Statement:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Minnesota Notice:** The clause "and/or authorization or agreement to bind the insurance" is replaced with "authorization or agreement to bind the insurance may be withdrawn or modified based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days notice given to the insured prior to the effective date of cancellation when he contract has been in effect for less than 90 days or is being canceled for nonpayment of premium."

**New York Disclosure Notice:**

**This policy is written on a claims made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged wrongful acts that took place prior to the out of incidents, occurrences or alleged wrongful acts that took place prior to the retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect and all coverage under the policy ceases upon termination of the policy except for the automatic extended reporting period coverage unless the insured purchases additional extended reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The insured may purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration of this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.**

If the primary address of the location listed in item #1 is in the state of **New York, Iowa or Florida**, the states of **New York, Iowa and Florida** require that we have the name and address of your (insured's) authorized Agent or Broker.

Name of authorized Agent or Broker \_\_\_\_\_

Address \_\_\_\_\_

Agent or Broker License number \_\_\_\_\_

Mail completed Application through local Agent or Broker to: \_\_\_\_\_

The undersigned represents that to the best of his/her knowledge and belief the particulars and statements set forth herein are true and agrees that those particulars and statements are material to acceptance of the risk assumed by the Company. The undersigned further declares that any changes to the information contained in this application prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The Company is hereby authorized, but not required to make any investigation and inquiry in connection with the information, statements and disclosures provided in this application. The decision of the Company not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Company and shall not estop the Company from relying on any statement in this application. The signing of this application does not bind the undersigned to purchase the insurance, nor does the review of this application bind the Company to issue a policy. It is understood the Company is relying on this application in the event the Policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued and it will be attached and become a part of the policy.

Signature: \_\_\_\_\_  
(Chairperson of the Board or President)

Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

IMPORTANT NOTE: This form is provided as a convenience to you. We will make a good faith effort to obtain competitive quotes for your review. Depending on the type of business, we may require more information and will contact you if necessary.

Your submission of this form DOES NOT guarantee that any binding offers will be forthcoming from insurers we represent.

Completion of this form neither binds coverage nor guarantees a policy will be issued.

Fax this form upon completion our office will fax you a notice of receipt within 24 hours, and may contact you for further information if needed. Fax (949) 270-3704