

# Employment Practices Liability

## APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

**THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY – PLEASE READ YOUR POLICY CAREFULLY**

1. Name of Organization: \_\_\_\_\_  
Primary Address: \_\_\_\_\_  
Person to contact in the event of a claim: \_\_\_\_\_ Phone #: \_\_\_\_\_  
If more than 1 location, attach a separate list including address, corporate name and number of employees at each location.
2. Purpose of Organization: \_\_\_\_\_
3. Total number of employees: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Temporary \_\_\_\_\_ Seasonal \_\_\_\_\_  
Independent Contractors \_\_\_\_\_ Leased \_\_\_\_\_ Other \_\_\_\_\_
4. Number of years in operation: \_\_\_\_\_
5. Has the Organization closed, downsized, laid off, reduced staff, sold, merged or acquired any company in the last 12 months or does the Organization plan to do so in the next 12 months?  Yes  No If yes, attach details.
6. Percentage of employees with total compensation including salaries, bonuses and commissions over \$50,000 \_\_\_\_\_%
7. Does the Organization currently carry Employment Practices Liability Insurance?  Yes  No  
If Yes, what is the effective date (month/day/year) of first year of continuous coverage? \_\_\_\_\_  
Who is the insurance carrier? \_\_\_\_\_
8. Does the organization want any subsidiary(s) covered?  Yes  No If yes, provide name(s), nature of operation and what percentage of ownership the organization has in the subsidiary? \_\_\_\_\_  
\_\_\_\_\_
9. How many employees have been involuntarily terminated or laid off in the past 12 mths? \_\_\_\_\_ 24 mths? \_\_\_\_\_
10. 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 claim supplement for each claim**
11. 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 claim supplement for each claim.**

**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.

**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.

**FRAUD STATEMENT (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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSANDS DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

**Mandatory Written Policies - please identify policies Applicant has in place:**

Sexual Harassment Policy (applies to employees and third parties)       Yes       No  
Anti-Discrimination Policy (applies to employees and third parties)       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.

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**Recommended Written Policies - please identify policies Applicant has in place:**

Employment Application       Yes       No  
Employee Handbook       Yes       No  
Company Email/Internet Policy       Yes       No

If Applicant has an Employee Handbook, Employment Application or Company Email/Internet Policy, a copy of each must be forwarded for review by the Company.

As a condition precedent to issuance of the policy for insurance the Applicant agrees:

- 1) to implement and distribute to each employee the Mandatory Written Policies identified above 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 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 of the Applicant's Written Policies as soon as possible, but no later than 21 days after receipt from the Company of the required changes .

The undersigned represents that to the best of his/her knowledge and belief the particulars and statements set forth herein are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place 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 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 agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued and it will become a part of the policy.

IF THE PRIMARY ADDRESS OF THE LOCATION LISTED IN ITEM #1 IS IN THE STATE OF NEW YORK, IOWA OR FLORIDA, THE STATE OF NEW YORK, IOWA AND FLORIDA REQUIRE THAT WE HAVE THE NAMES AND ADDRESS OF YOUR (INSURED'S) AUTHORIZED AGENT OR BROKER.

NAME OF AUTHORIZED AGENT OR BROKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

AGENT OR BROKER LICENSE NUMBER: \_\_\_\_\_

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Signature of President or Chairman

Date