



www.CoverX.com

**SOUTHFIELD**

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**BOSTON**

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**IMPORTANT – To be completed by Producer:**

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

Producer Is:  Wholesaler  Retailer

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_

If Renewal, Provide Current Policy No.: \_\_\_\_\_

**IMPORTANT – To be completed by Producer who will handle the Surplus Lines transaction(s):**

**Resident or Non-Resident Surplus Lines Licensee Information for Applicant's State of Domicile:**

SL Licensee Agency Name: \_\_\_\_\_

SL License State: \_\_\_\_\_

SL License No.: \_\_\_\_\_

SL License Expiration Date: \_\_\_\_\_

SL Licensee Name (if not an Entity License): \_\_\_\_\_

Affiliation with Producer (e.g., Owner, Executive Officer, Employee): \_\_\_\_\_

**LIMITS OF PROFESSIONAL LIABILITY INSURANCE REQUESTED**

\$1,000,000  \$2,000,000  \$3,000,000  \$4,000,000  \$5,000,000

**DEDUCTIBLE LIMIT REQUESTED**

\$5,000  \$10,000  \$15,000  \$20,000  \$25,000  Other: \_\_\_\_\_

**TYPE OF POLICY LIMIT AND COVERAGE REQUESTED**

Stand Alone Employment Practices  Shared Limit with Directors and Officers  Separate Limit with Directors and Officers

## Employment Practices Liability Insurance Application

**Instructions to the Applicant:**

1. Please answer all questions completely. Your answers will be used to make important underwriting and pricing decisions and are considered legally material to all decisions made by us.
2. The application and any supplemental documents must be signed and dated by an authorized person of the prospective Applicant to be insured.
3. Please attach any consolidated EEO1 Report for any Applicant with more than 100 employees.
4. Please attach your most recent financial statements.
5. Please attach a copy of your written policy for discrimination, harassment and retaliation.
6. Please attach a copy of your Handbook (for any Applicant with more than 350 employees).

**Important to Note:** This is an application for a Claims Made and Reported Policy and subject to all Policy Provisions. It will apply only to Claims Made within the policy period and reported as soon as practicable subject to any extended reporting period, if applicable. The Limit of Liability available to pay settlements; judgments and or pay damages shall be reduced by the amount of Defense Costs incurred.

**GENERAL INFORMATION:**

1. Applicant's Legal Name: \_\_\_\_\_
2. Street Address: \_\_\_\_\_  
Mailing Address (if different than above): \_\_\_\_\_
3. Website Address: \_\_\_\_\_
4. Name of Risk Manager or Officer contact person: \_\_\_\_\_ Telephone No.: \_\_\_\_\_
5.  Individual  Corporation  Partnership  Privately Held  Not-For-Profit  Publicly Traded  
 Other (Describe): \_\_\_\_\_
6. Date Established: \_\_\_\_\_ SIC Code or NAIC Code (if known): \_\_\_\_\_
7. Nature of Operations: \_\_\_\_\_
8. Is the Applicant owned, controlled, affiliated, or associated with any other entity?  YES  NO  
If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
  
Does the Applicant have any franchise operations?  YES  NO  
If Yes, how many franchise units does Applicant have and where are they located? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. What are the Applicant's Assets and Liabilities? Assets \$ \_\_\_\_\_ Liabilities \$ \_\_\_\_\_  
What are the Applicant's Gross Revenues? \$ \_\_\_\_\_

**INSURANCE HISTORY:**

10. Please provide the following information as respects prior professional liability or errors and omissions insurance coverage during the last 3 years: (If occurrence coverage, please indicate under retro date.)

| Insurance Company | Policy Term | Limit of Insurance | Deductible Amount | Retro Dates | Premium |
|-------------------|-------------|--------------------|-------------------|-------------|---------|
|                   |             |                    |                   |             |         |
|                   |             |                    |                   |             |         |
|                   |             |                    |                   |             |         |

11. If Comprehensive General Liability coverage is maintained, please indicate as follows:

| Insurance Company | Policy Term | Insurance Limit | Premium |
|-------------------|-------------|-----------------|---------|
|                   |             |                 |         |

12. If Directors and Officers coverage is maintained, please indicate as follows:

| Insurance Company | Policy Term | Insurance Limit | Premium |
|-------------------|-------------|-----------------|---------|
|                   |             |                 |         |

13. If Errors and Omissions coverage is maintained, please indicate as follows:

| Insurance Company | Policy Term | Insurance Limit | Premium |
|-------------------|-------------|-----------------|---------|
|                   |             |                 |         |

If any of the above coverages are restricted, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Has any insurance ever been cancelled or declined?  YES  NO  
 If Yes, please explain: \_\_\_\_\_

(Note: Applicants in Missouri are not required to answer this question.)

**APPLICANT HISTORY:**

15. Has Applicant acquired any companies over the past year?  YES  NO  
 If Yes, were any employees terminated or are there plans to terminate them over the next 12 months?  YES  NO

16. Were there any significant changes in the nature or size of the Applicant over the last 12 months? \_\_\_\_\_  
 Have there been any layoffs?  YES  NO  
 If Yes, please explain and advise as to the total number of employees affected; whether a severance and release was offered and obtained. Finally, advise whether in-house legal counsel or outside legal counsel reviewed the layoffs and/or severance and release plan: \_\_\_\_\_

17. Is Applicant aware of any reductions in force or layoffs contemplated to occur in the next 12 months?  YES  NO  
 If Yes, please explain: \_\_\_\_\_

18. Enter total number of employees (by category) in the boxes below:

|                         | Present Year | Last Year | Location (State) |
|-------------------------|--------------|-----------|------------------|
| Full Time US Employees  |              |           |                  |
| Part Time US Employees  |              |           |                  |
| Foreign Employees       |              |           |                  |
| Independent Contractors |              |           |                  |

19. Enter the number of employees in the specified states in the boxes below:

|                               | Florida | California | Texas |
|-------------------------------|---------|------------|-------|
| Number of Full Time Employees |         |            |       |
| Number of Part Time Employees |         |            |       |

20. Please provide the annual percentage of Applicant's employee turnover for the past 3 years for the entire business:

| Year | Percent % |
|------|-----------|
|      |           |
|      |           |
|      |           |

Please provide the annual percentage of involuntary terminations for the past 3 ears for the entire business:

| Year | Percent % |
|------|-----------|
|      |           |
|      |           |
|      |           |

21. Please indicate the Applicant's percentage of employees' salaries:

- Less than \$20,000 \_\_\_\_\_ %
- \$20,001 through \$50,000 \_\_\_\_\_ %
- \$50,001 through \$75,000 \_\_\_\_\_ %
- \$75,001 through \$99,999 \_\_\_\_\_ %
- Greater than \$100,000 \_\_\_\_\_ %

22. Does the Applicant have an exposure to Third Parties; including customers, clients, visitors? For example, is the Applicant seeking insurance coverage for customer complaints of harassment and/or discrimination against employees of Applicant?  
 YES NO If Yes, please explain what type of Third Party Exposure the Applicant has? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
23. Does the Applicant have a written policy and procedure for dealing with complaints from Third Parties? YES NO
24. Please provide the following information with reference to Human Resources and Risk Management Functions:
- |   |                            |
|---|----------------------------|
| Does the Applicant have a written employee handbook?  | YES NO                     |
| Does the Applicant have a written sexual harassment policy?   | YES NO                     |
| Does the Applicant have a written non-discrimination policy?  | YES NO                     |
| Does the Applicant provide a copy of the handbook to all employees?   | YES NO                     |
| Does the employee receive a copy electronically including management?   | YES NO                     |
| Does the Applicant maintain written acknowledgements of the employees receiving a copy of their handbook and updates?                           | YES NO                     |
| Does the Applicant have a full-time HR manager?<br>How many employees are a part of the HR staff? _____   | YES NO                     |
| Does the Applicant require an application for employment?   | YES NO                     |
| Does the Applicant provide written performance reviews annually to all of their employees?  | YES NO                     |
| Does the Applicant have written procedures with regard to progressive discipline?<br>Up to and including terminations?                          | YES NO<br>YES NO           |
| Does the Applicant screen or test employees or Applicants for promotions?   | YES NO                     |
| Does the Applicant have a written ADA (disability) policy?  | YES NO                     |
| Does the Applicant have a written medical leave and family leave policy?  | YES NO                     |
| Does the Applicant provide harassment, discrimination and retaliation training sessions for Managers?<br>If Yes, Quarterly?<br>Yearly?          | YES NO<br>YES NO<br>YES NO |
| Does the Applicant provide harassment, discrimination and retaliation training sessions for all employees?<br>If Yes, Quarterly?<br>Yearly?     | YES NO<br>YES NO<br>YES NO |
| Does the Applicant have a written pregnancy leave policy?   | YES NO                     |
| Does the Applicant require employees/Applicants to submit to drug testing?<br>If Yes, does the Applicant have a drug testing policy?            | YES NO<br>YES NO           |
| Does the Applicant conduct criminal background checks on Applicants?  | YES NO                     |
| Does the Applicant conduct criminal background checks on current employees?   | YES NO                     |
| Does the Applicant maintain job descriptions for employees?   | YES NO                     |
| Does the Applicant require Applicants/employees to sign a binding arbitration agreement or waiver of jury trials for employment related claims? | YES NO                     |
| Does the Applicant have multiple avenues for employee to make formal or informal complaints relating to their employment?                       | YES NO                     |
| Does the Applicant provide a hotline number for employees to make formal or informal complaints?  | YES NO                     |
| Who is required to review possible terminations?<br>Risk Management / Human Resources<br>In-House Legal Counsel<br>Outside Counsel              | YES NO<br>YES NO<br>YES NO |
25. Please provide or describe the Applicant's system for reviewing and monitoring diversity in the work place. If required to file a formal Affirmative Action Plan, please attach a sample: \_\_\_\_\_  
 \_\_\_\_\_

**CLAIMS HISTORY:**

26. Is the Applicant aware of any fact or circumstance which may reasonably be expected to lead to a claim or potential claim against Applicant or any other person past or present in your organization?  YES  NO If yes, please explain (Include names of potential claimants, nature of allegations, dates services were provided and amount demanded):

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27. Please indicate the name of the Applicant's law firm or counsel used for employment related issues (includes claims, EEOC, State charges, demand letters or formal litigation):

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28. Does the Applicant have a written policy for handling complaints including Third Parties?  YES  NO  
Who is responsible for handling the investigation:

In-House Human Resources?  YES  NO

In-House Counsel?  YES  NO

Outside Counsel?  YES  NO

29. Who is responsible for answering State/Local Administrative Charges or EEOC complaints:

In-House Human Resources?  YES  NO

In-House Counsel?  YES  NO

Outside Counsel?  YES  NO

30. How does the Applicant maintain personnel files for current and former employees?  
Please explain:

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31. Please explain how the Applicant administers its workers compensation program. For example, does the Applicant self-administer the program or does a Third Party Administrator or insurance company do so?

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32. What percent % of Applicant's employees are hourly versus salary? \_\_\_\_\_

34. Please list all employment practices liability claims from the past 5 years as indicated:

| DATE OF CLAIM | DESCRIPTION OF CLAIM | PAID LOSS | PAID EXPENSE | AMOUNT OUTSTANDING/RESERVED | OPEN (O) OR CLOSED (C) CLAIM |
|---------------|----------------------|-----------|--------------|-----------------------------|------------------------------|
|               |                      |           |              |                             |                              |
|               |                      |           |              |                             |                              |
|               |                      |           |              |                             |                              |
|               |                      |           |              |                             |                              |
|               |                      |           |              |                             |                              |

Please list any additional information below:





**NOTICE:**

- 1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NONADMITTED” OR “SURPLUS LINE” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
- 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
- 4. CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE:[www.insurance.ca.gov](http://www.insurance.ca.gov).**
- 5. FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
- 6. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER’S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

Date: \_\_\_\_\_  
Insured: \_\_\_\_\_