Name of Insurance Company to which application is made

APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE FLORIDA

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.

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

Instructions:

A. Answer all questions. If the answer to any question is NONE, please state NONE.
B. If the space to answer any question fully is insufficient, attach a separate sheet.
C. The application must be signed and dated by the owner, partner, or officer and by a human resources or personnel officer.
D. **PLEASE READ CAREFULLY THE STATEMENT AT THE END OF THIS APPLICATION.**

GENERAL INFORMATION

1. Applicant's name and address:
   (Please include the names of all companies and subsidiaries which are to be covered if the policy is issued.)

2. Name, title, and phone number of person to contact:

3. Describe the applicant's operations and give the number of locations by state:

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4. Coverage desired:

Limit of Liability: ______________________ Proposed Effective Date: ______________

Deductible: ______________________ Retroactive Date: ______________

---

5. Do you currently carry Employment Practices Liability Insurance? ☐ Yes ☐ No

If yes, please provide details as to the Insurer, the limits of liability, deductibles, retroactive date and premium.

---

6. Do you currently carry Directors and Officers liability insurance? ☐ Yes ☐ No

If yes, please provide the name of the carrier and also indicate the limits of liability?

---

7. 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, Montana, Missouri, Ohio, and / or New Jersey	______	______
All other states	______	______
Total	______	______

b. Indicate below by their salary ranges the number of employees:

Salary ranges	**full-time**	**part-time**
$ 30,000 or less per year	______	______
$ 30,001 - $ 50,000 per year	______	______
$ 50,001 - $100,000 per year	______	______
Over $100,000 per year	______	______
Total	______	______

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

______ ______% ______ ______% ______ ______% ______ ______%

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

______ ______ ______ ______ ______ ______ ______ ______

e. Do any employees have written contracts of employment? ☐ Yes ☐ No

If yes, how many? ______ Please attach a specimen contract.

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LOSS HISTORY

8. a. Regardless of whether or not such loss may have been 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 proceeding (federal, state, or local) concerning employment termination, discrimination, sexual harassment, wage and hour violations, and 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 $ 10,000 (including amounts paid or reserved for the defense of the claim or proceeding)? ☐ Yes ☐ No

If yes, please complete and attach the **EMPLOYMENT PRACTICES LIABILITY APPLICATION CLAIM SUPPLEMENT** for each such claim or proceeding. If there were no claims or proceedings paid or reserved in excess of $ 10,000 state NONE. ____________

c. Are you aware of actual or alleged wrongful employment practices or other facts incidents, or circumstances that may result in claims being made against you? For purposes of this question, wrongful employment practices include employment terminations, constructive discharge from employment, discrimination for whatever reason, and sexual harassment.

☐ Yes ☐ No

If yes, please explain on a separate sheet.

IT IS UNDERSTOOD AND AGREED THAT AS TO ANY WRONGFUL EMPLOYMENT PRACTICE CLAIM, WRONGFUL EMPLOYMENT PRACTICE, FACT, INCIDENT, OR CIRCUMSTANCE THAT ARE OR SHOULD BE DISCLOSED IN RESPONSE TO QUESTIONS 8. a., b., OR c. ABOVE, ANY CLAIM ARISING THEREFORM IS EXCLUDED FROM COVERAGE UNDER THE POLICY FOR WHICH THIS APPLICATION IS MADE.

HUMAN RESOURCES DEPARTMENT

9. a. Do you have a Human Resources or Personnel Department? ☐ Yes ☐ No

How many employees are in this department? ____________

If no, please provide details on the handling of this function on a separate page.

b. 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. ____________

c. Provide the name and address of any firm performing employee review, disciplinary, or employee hiring services, and furnish a description of the services provided.

____

d. Do you use a written employment application form for your employment applicants? ☐ Yes ☐ No

e. Do you make use of tests to screen employment applicants? ☐ Yes ☐ No

If yes, please provide details.

____

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f. Do you have an employment handbook? ☐ Yes ☐ No
If yes, is the handbook distributed to all of your employees? ☐ Yes ☐ No

g. Do you have a formal orientation program for all new employees? ☐ Yes ☐ No
If yes, please provide details.

____

____

h. Do you conduct regular written performance evaluatio0ns of all your employees? ☐ Yes ☐ No

i. Do you have an affirmative action plan? ☐ Yes ☐ No
If yes, please provide a copy.

k. 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) AIDS or assisting employees with life threatening or communicable diseases? ☐ Yes ☐ No
4) accommodating the disabled in accordance with the Americans With Disabilities Act? ☐ Yes ☐ No
5) the Family and Medical Leave Act of 1993? ☐ Yes ☐ No

If you answered yes to any of the items in this question 9., 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.

---

10. 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

---

11. 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).

---

12. Do you anticipate any lay-offs or reduction in force (RIF) within the next twenty-four (24) months? ☐ Yes ☐ No
If yes, please provide details on a separate page(s).

---

13. Do you have written procedures for disciplining employees? ☐ Yes ☐ No

---

14. Do you have written procedures for terminating employees? ☐ Yes ☐ No

---

CORPORATE HISTORY

15. a. Has your business name changed? ☐ Yes ☐ No
If yes, list all former names on a separate sheet.

b. 1) Have you acquired any new subsidiaries or other business organizations in the last five (5) years? ☐ Yes ☐ No
2) If yes, did the purchase include the assumption of liabilities? ☐ Yes ☐ No
3) If yes, does the information provided in response to Question 8. include these ☐ Yes ☐ No

acquired subsidiaries or organizations?

4) With respect to acquired subsidiaries or organizations, were any employees or officers terminated or do you plan in the next eighteen (18) months to terminate any employees or officers? ☐ Yes ☐ No

c. 1) Have you sold any subsidiaries or other business organizations in the last five (5) years? ☐ Yes ☐ No

2) Did the sale include the transfer of liabilities to the purchaser? ☐ Yes ☐ No

---

CLAIMS HANDLING PROCEDURES

16. a. Who in the insured's organization will be responsible for the reporting of claims to the insurer under any policy that may be issued pursuant to this application?

Name: ______________________ Title: ______________

Address: ______________________________________

____

Telephone Number (include area code): ______________________

b. Who in the insured's organization will be responsible for handling claims in conjunction with the insurer under any policy that may be issued pursuant to this application?

Name: ______________________ Title: ______________

Address: ______________________________________

____

Telephone Number (include area code): ______________________

c. With respect to claims, incidents, etc.:

1) Do you have a written procedure for obtaining information: ☐ Yes ☐ No
If yes, please provide a copy.

2) Have you made supervisory personnel aware in writing of your desire for prompt notice? ☐ Yes ☐ No
If yes, please provide a copy.

THIS APPLICATION WILL ONLY BE PROCESSED IF THE FOLLOWING <u>APPLICABLE</u> INFORMATION IS INCLUDED. FAILURE TO INCLUDE THE <u>APPLICABLE</u> INFORMATION FOR ANY COMPANY TO BE COVERED BY THIS INSURANCE WILL DELAY THE ISSUANCE OF A QUOTE UNTIL THE INFORMATION IS RECEIVED OR WILL RESULT IN A QUOTE EXCLUDING THE COMPANY(IES) FOR WHICH THE INFORMATION HAS NOT BEEN RECEIVED.

Indicate attachments by an (X):

a. ☐ Financial Statements
b. ☐ Securities and Exchange Commission Form 10-K
c. ☐ Employee Handbook, manual, and work rules
d. ☐ Employee disciplinary, termination and out-placement procedures
e. ☐ Employment Application Form(s)
f. ☐ Supervisory Manual(s)
g. ☐ Employee Performance Form(s)
h. ☐ EEO-1 Report

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THE UNDERSIGNED AUTHORIZED APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION 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 "EEFECTIVE DATE" IS THE DATE THE COVERAGE IS BOUND OR THE FIRST DAY OF THE CURRENT POLICY PERIOD, WHICHEVER IS LATER.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION 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 APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

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.

NOTE: BOTH SIGNATURE LINES MUST BE COMPLETED.

Date	Applicant's Authorized Signature of a Principal, Partner, or Officer	Title
	Please Print Name	
Date	Applicant's Authorized Signature of individual in charge of the Human Resources or Personnel Department	Title
	Please Print Name	

Agent Name	Agent License Number

PLEASE SUBMIT THIS PROPOSAL AND APPROPRIATE MATERIALS TO:

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

APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE

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 a separate sheet 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 CLAIMS: ☐ PENDING ☐ CLOSED ☐ IN SUIT

8) IF CLOSED, TOTAL DAMAGES 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 OUR 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 EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION AND IS SUBJECT TO THE SAME ONDITIONS.

______________________________ ______________________________

APPLICANT'S SIGNATURE DATE

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SUPPLEMENT I: THIRD PARTY CLAIM QUESTIONNAIRE
FLORIDA

1. Does the **Insured's** current Employment Practices Liability Policy provide Third Party Insurance? ☐ Yes ☐ No
   Limit: ________________ Retention: _________________ Pending and Prior Litigation Date: ______________

2. Does the **Insured** have a written policy prohibiting all forms of harassment, discrimination, and civil rights violations committed against customers, clients, vendors and/or other third parties? ☐ Yes ☐ No

3. Does the **Insured** have established written procedures for handling third party complaints of harassment, discrimination, and civil rights violations? (If yes, attach a copy of these written procedures.) ☐ Yes ☐ No

4. **(a)** Does the **Insured** conduct training on third party discrimination, harassment (including sexual) and civil rights violation prevention? ☐ Yes ☐ No
   (b) Who is required to attend this training?____
   (c) Who conducts the training?____
   (d) How often is training conducted?____
   (If necessary, please attach a separate sheet.)

5. **(a)** During the past five years has the **Insured** ever had a claim, circumstance or incident brought against them by a customer, client, vendor and/or third party? ☐ Yes ☐ No
   (b) If yes, please attach a list of all such matters. Include a description of the allegations, name of the plaintiff(s), name of the defendant(s), the defense counsel, court involved, current status, defense costs, indemnity costs and reserves.
   (c) If yes, what steps has the **Insured** taken to eliminate or mitigate the chances of a similar problem in the future?
   ____

6. Approximately what percentage of the **Insured's Employees** is in contact with customers, clients, vendors and/or other third parties? _____%

7. Do any of the Applicant's **Employees** work at customer, client, vendor or other third party locations? ☐ Yes ☐ No

8. **(a)** Do **Employees** of any third party (i.e. security guards, etc.) perform services at your facilities? ☐ Yes ☐ No
   (b) If yes, are they provided with a copy of the **Insureds** written policies and procedures as outlined in questions 1 and 2 above? ☐ Yes ☐ No

9. **(a)** Does the **Insured** have contractual agreements with third parties that perform services at their facilities? ☐ Yes ☐ No
   (b) Are the agreements in writing? ☐ Yes ☐ No
   (c) Does it include a written agreement to hold the **Insured** harmless and/or indemnify the **Insured** for wrongful actions by such third parties? ☐ Yes ☐ No

10. **(a)** Does the **Insured** extend credit to any customer, client or other third party? ☐ Yes ☐ No
    (b) If yes, is it done internally or is it outsourced? ____

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(c) If it is outsourced, does the **Insured** require the vendor to follow the written policies and procedures as outlined in questions 1 and 2 above? ☐ Yes ☐ No

11. **(a)** Does the **Insured** have any franchise operations, leased workers or independent contractors? ☐ Yes ☐ No

(b) If yes, does the **Insured** require them to follow the policies and procedures as outlined in questions 1 and 2 above? ☐ Yes ☐ No

12. Are any of the **Insured's Employees** compensated by commission? ☐ Yes ☐ No

If yes, please include job descriptions and the percentage of staff that work on commission:

____

13. **(a)** Are all of the **Insured's** locations in compliance with the American with Disabilities Act? ☐ Yes ☐ No

(b) Are all the **Insured's** entrances, exits and restrooms accessible to the disable, and in compliance with the American with Disabilities Act? ☐ Yes ☐ No

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______________________	______________________
Agent Name	Agent License Number
______________________	______________________
Applicant's Signature	Date

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SUPPLEMENT II: FOREIGN OPERATIONS EXPOSURE QUESTIONNAIRE FLORIDA

(Complete this section should coverage be requested for Foreign Operations Exposure)

1. Foreign Exposure (attach a separate form if necessary)

Country	Nature of Operations	Relationship to **Parent Company** (*see chart below)	Total Number of **Employees**	Total Number of Full-Time **Employees**	Total Number of Part-Time **Employees**

*Relationship to **Parent Company**
- A = **Subsidiary**
- B = Affiliate
- C = Joint Venture
- D = Other – please describe

2. **Loss** History

(a) Please provide complete employment-related **Claim** and circumstance information for the past five (5) years. The list should include for each complaint, litigation or proceeding: (i) the type of allegation(s), (ii) the country, court and agency involved, (iii) description of any decision, determination or judgment rendered, (iv) total defense costs incurred to date in the litigation or proceeding, (v) any judgment or settlement amount and (vi) whether the litigation or proceeding remains pending or is closed.

(b) Describe how a non-U.S. employment **Claim** will be investigated and managed:
(If necessary, attach a separate form) ______________________________

____

____

(c) Who is responsible for handling of non-U.S. **Claims**?
Name: ______________________ Title: ______________________

Location: ______________________________

3. Employment Practices

(a) Do the foreign operations utilize the same employment policies and procedures as the U.S. operations?
☐ Yes
☐ No (If no, describe and attach any policies or procedures that are unique to the foreign operations.)

____

(b) Is there a director of human resources for non-U.S. operations?
☐ Yes (If yes, who does he/she report to?) ______________________
☐ No (If no, how does the **Insured** insure that all employment policies and procedures are enforced?) ______________________

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(c) Please provide an organizational chart which depicts where the non-U.S. Human Resources function exists.

(d) Have all the non-U.S. operations handbooks, employment contracts, employment applications, employment and labor policies and procedures been reviewed by outside counsel familiar with local and foreign employment/labor law, rules, and regulations?

☐ Yes (If yes, when were they last reviewed and updated?) ____________________

☐ No

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______________________________	______________________________
Agent Name	Agent License Number
______________________________	______________________________
Applicant's Signature	Date

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SUPPLEMENTAL CLAIM FORM
FLORIDA

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 that may give rise to a claim. Please complete a separate sheet for each claim or incident and answer all questions fully.

1. The date the **Claim** was made: ________________________________

2. The name of defendant (s): ________________________________

3. The name of complainant (s): ________________________________

4. Insurance carrier(s) in which the **Claim** was reported: ________________

5. Type of **Claim**: Demand Letter – Attorney ____ Demand Letter – Complainant____ Lawsuit___ EEOC___
   Other Administrative Agency ____

6. Status of the **Claim**: Pending ___ Closed ____

   If closed:
   What were the total damages paid? $_____
   What were the total expenses paid? $_____
   What was the date closed? ________

   If pending:
   Is there a settlement demand? Yes ___ No ___
   What is the complainant's demand amount? $_______
   What are the total expenses paid to date? $________
   What are the anticipated costs (defense and expense)? $____

7. Please provide a detailed description of the **Claim**. Include allegations and the Insured's response to the allegations:
   ____
   ____
   ____

8. What steps have been taken to prevent and/or mitigate a recurrence or similar **Claim** in the future?
   ____
   ____
   ____

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________________________ ________________________
Agent Name Agent License Number

________________________ ________________________
Applicant's Signature Date

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SUPPLEMENT III - REDUCTION IN WORKFORCE QUESTIONNAIRE
FLORIDA

(Complete this section if the Policyholder in the past 36 months completed or agreed to, or contemplates within the next 18 months any plant, facility, branch or office closing, consolidation or layoff)

1. Please provide the following workforce details: (Please provide a separate sheet if necessary)

Date of reduction in workforce	Reason for reduction in workforce	Number of **Employees** affected by the reduction

2. Did or will the reduction in workforce comply with the Worker Adjustment and Retraining Notification Act (WARN)? ☐ Yes ☐ No
3. Who will make or who made the decision to reduce the workforce?____________________
4. Does the **Insured** have a reduction in workforce committee? ☐ Yes ☐ No
   If yes, please provide details:____________________
5. Were/are impact studies conducted? ☐ Yes ☐ No
   If yes, what were the findings? ____________________
6. (a) Please provide a breakdown of the number of **Employees** to be affected by the reduction:

Category	Total Number of **Employees**	Category	Total Number of **Employees**
Male		Female	
Male White		Female White	
Male Minorities		Female Minorities	
Male Officials & Managers		Female Officials & Managers	
Male Minorities Officials & Managers		Female Minorities Officials & Managers	
Male 40 & Older		Female 40 & Older	
Male Minorities 40 & Older		Female Minorities 40 & Older	

   (b) What are the criteria to determine the workforce reduction?
   ☐ departmental/specific positions ☐ seniority ☐ performance ☐ arbitrary ☐ combination of all
   Please provide details____________________
7. (a) Was/is severance available to all **Employees**? ☐ Yes ☐ No
   If no, please provide details: ____________________
   (b) Is the severance package uniform? ☐ Yes ☐ No
   (c) Please attach severance package details.
8. (a) Were/are the **Employees** required to sign a release for the severance package? ☐ Yes ☐ No
   If yes, does it comply with the Age Discrimination in Employment Act (ADEA) and Older Worker Benefit Protection Act ("OWBPA")? ☐ Yes ☐ No
   (b) Did any **Employee** refuse to sign the release? ☐ Yes ☐ No
   (c) Please provide a copy of any waiver(s) and/or releases(s).
9. (a) Are outplacement services provided? ☐ Yes ☐ No
   If yes, are they provided to all **Employees**? ☐ Yes ☐ No
10. (a) Are exit interviews conducted? ☐ Yes ☐ No
    (b) Are they standardized? ☐ Yes ☐ No
    (c) Are they documented in writing? ☐ Yes ☐ No
    (d) Do they require the **Employee's** signature? ☐ Yes ☐ No

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11. (a) Were any **Claims** filed, or are any expected to be filed, as a result of this reduction in workforce?
☐ Yes ☐ No

(b) Have any of the **Employees** effected by the reduction in workforce previously filed complaints or **Claims** of discrimination, harassment, disability or workers compensation? ☐ Yes ☐ No
If yes, please provide details on a separate sheet including the date(s) of the most recent complaint(s) or **Claim(s)** by each such **Employee**.

12. Did the **Insured** consult with outside counsel familiar with employment and labor law regarding the reduction in workforce process? ☐ Yes ☐ No
If yes, which law firm was consulted? ______________________________

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______________________________ ______________________________
Agent Name Agent License Number

______________________________ ______________________________
Applicant's Signature Date

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