Name of Insurance Company to which Application is made

APPLICATION FOR EMPLOYMENT PRACTICES LIABILTY INSURANCE

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, THE AMOUNTS INCURRED FOR DEFENSE AND OTHER **CLAIM** EXPENSES SHALL BE APPLIED 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. Terms appearing in bold face in this Application are defined in the Policy and have the same meaning in this Application as in the Policy. If you do not have a copy of the Policy, please request it from your agent or broker.
C. If the space to answer any question fully is insufficient, please attach a separate sheet.
D. The Application must be signed and dated by the owner, partner, or officer, and by a human resources or personnel officer.
E. PLEASE READ CAREFULLY THE STATEMENT AT THE END OF THIS APPLICATION.

1. GENERAL INFORMATION

Applicant Name : _____
(Please include the names of all **Companies** and **Subsidiaries** which are to be covered if the policy is issued. Include the nature of business, date acquired or formed, number of **Employees**, and percentage of ownership)
Address: _____
State of Incorporation: _____
The **Insured** has been in continuous operation since: _____
Description of All Operations: _____
SIC Code: _____ Type of **Company**: ☐ Private ☐ Public Stock Symbol _____
Type of Organization: ☐ Corporation ☐ Partnership ☐ Joint Venture ☐
Other_____
Website Address: _____
Designated representative to receive all notices from the Insurer on behalf of **Insureds** and **Insured Persons** proposed for this insurance:
Name: _____ Title: _____
Address: _____
Telephone: _____ Fax: _____ Email: _____

2. COVERAGE REQUESTED

Limit of Liability: _____ Self Insured Retention: _____ Continuity Date: _____
Proposed **Policy Period**: From: _____ To: _____ Pending and Prior Litigation Date:
_____

3. PRIOR INSURANCE

a. Does the **Insured** currently have Employment Practices Liability Insurance? ☐ Yes ☐ No

If yes, please provide the following details:
Insurance
Carrier:_____
Limit of Liability: $_____ Self Insured Retention: $_____ Premium: $_____
Policy Period _____Continuity Date _____

b. Have any of the **Insured's** current or previous Employment Practices Liability insurers refused to offer renewal terms? ☐ Yes ☐ No
If yes, please provide details: _____

4. THIRD PARTY CLAIM COVERAGE

Is the **Insured** requesting Third Party Claim coverage? ☐ Yes ☐ No
If yes, please complete *Supplement I, Third Party Claim Questionnaire.*

5. PUNITIVE DAMAGE COVERAGE

Is the **Insured** requesting punitive damages coverage? ☐ Yes ☐ No

6. OTHER INSURANCE

Does the **Insured** currently carry the following insurance?

a. Directors and Officers Liability ☐ Yes ☐ No
Insurance Carrier:_____
Limit of Liability: $_____ Premium: $_____ **Policy Period** _____

b. General Liability ☐ Yes ☐ No
Insurance Carrier:_____
Limit of Liability: $_____ Premium: $_____ **Policy Period** _____

c. Umbrella Liability ☐ Yes ☐ No
Insurance Carrier:_____
Limit of Liability: $_____ Premium: $_____ **Policy Period** _____

7. EMPLOYEE INFORMATION

a. Does the **Insured** have any foreign operations? ☐ Yes ☐ No
If coverage for foreign operations is desired, please complete *Supplement II, Foreign Exposure Questionnaire*.

b. Please provide the total number of **Employees** in the **Parent Company** and all **Subsidiaries** that are to be covered if a Policy is issued :

_____Full-Time	_____Leased	_____Independent Contractors
_____Part-Time		_____Volunteers
		_____Unionized Workers
_____Temporary/Seasonal	_____Outside the United States	

c. Please provide a breakdown of the total number of **Employees** or **Insured Persons** in the following geographical locations:
_____CA _____D.C. _____FL _____IL _____LA _____MA _____MI _____NJ
_____NY _____TX _____WA

d. Please provide a breakdown of the total number of other workers, **Employees** or **Insured Persons** with the following salaries:

$ 50,000 or less per year	_____
$ 50,001 - $100,000 per year	_____
$100,001 - $150,000 per year	_____
$150,001 - $250,000 per year	_____
Over $250,000 per year	_____

e. What is the percentage of **Employees** over 40 (forty) years of age: _____%

f. Does the **Insured** have a tracking system that monitors the overtime, vacation and sick pay hours of non-exempt **Employees**? ☐ Yes ☐ No

g. Please provide **Employee** turnover for the most recent 3 (three) years:
Year _____ _____% Year _____ _____% Year _____ _____%

h. For each of the last three (3) years, indicate the number of officers and other **Employees** that have been involuntarily terminated: Year _____ _____ Year _____ _____ Year _____ _____

i. Does the **Insured** have a written employment contract with any **Employee** or **Insured Person**? ☐ Yes ☐ No
If yes, are the employment contracts created and reviewed by outside employment/labor counsel?
☐ Yes ☐ No

Total number of employment contracts: _____
Total value of all contracts: $_____
Total value of largest contract: $_____

Please provide a specimen contract.

8. PAST ACTIVITIES

Please state below whether any **Insured** has been involved in any of the following and provide details for any "yes" response:

a. Qui tam action? ☐ Yes ☐ No

b. Civil or criminal action or administrative proceeding charging a violation of a federal, state, local, or foreign employment law or regulation? ☐ Yes ☐ No

c. Any other criminal actions? ☐ Yes ☐ No

d. Representative actions, class actions or derivative suits in connection with employment issues? ☐ Yes ☐ No

e. Investigation by the Equal Employment Opportunity Commission (EEOC) or similar state, local or foreign agency? ☐ Yes ☐ No

f. Is any **Insured** presently subject to any judicial or administrative order, decree, judgment or conciliation agreement that is employment-related? ☐ Yes ☐ No

9. CLAIM HISTORY

a. Regardless of whether or not such **Claim(s)** may have been covered by any insurance policy, please provide a list of all employment-related complaints, grievances, arbitrations, charges, litigation, investigations and administrative proceedings (including Equal Employment Opportunity Commission (EEOC) or other federal, state and local agency proceedings, such as proceedings involving the National Labor Relations Board (NLRB), U.S. Department of Labor (DOL), U.S. Department of Justice (DOJ), or the Office of Federal Contract Compliance Programs (OFCCP) commenced against any **Insured** during the past five (5) years. The list should include: (a) date of **Claim(s)**, (b) a description of the allegation, (c) the court or agency involved, (d) description of any decision, determination or judgment rendered, (e) total **Claim(s) Expenses** incurred to date, (f) any judgment or settlement amount, (g) whether the **Claim(s)** remains pending or closed, (h) if pending, provide demand amount, and (i) what corrective action has been taken to mitigate or prevent such **Claim(s)** from occurring or recurring.

b. Are you aware of actual or alleged **Wrongful Acts** or other acts, errors, omissions, facts, situations or circumstances that may result in a **Claim(s)** within the scope of the proposed insurance being made against you? ☐ Yes ☐ No

c. Has any **Insured** given written notice under the provisions of any prior or current Employment Practices Liability policy or similar insurance policy of specific facts or circumstances that might give rise to a **Claim** being made against the Applicant? ☐ Yes ☐ No

d. Have any **Loss** payments been made on behalf of any proposed **Insured** under any liability policy or similar insurance? ☐ Yes ☐ No

If answered yes to any of the above, please complete *Supplement III, Supplemental Claim Form*.

It is agreed that with respects to the questions 8 and 9, if such facts or circumstances exist, any **Claim(s)** arising therefrom are excluded from the proposed insurance for all **Insureds**.

10. PRIOR EXPERIENCE

No **Claim(s)** have been made against any entity(ies) or person(s) proposed for this insurance in a capacity that would be insured under this policy (including **Loss** payments and **Claim Expenses**).

If there are any exceptions, please attach complete details. ☐ None

It is agreed that with respects to question 10 above, any **Claim** based upon, arising from, or in any way related to any act, error, omission, fact or circumstance of which any **Insured** has any knowledge or information will be excluded from coverage under the proposed insurance.

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11. EMPLOYMENT POLICIES AND PROCEDURES

a. Does the **Insured** have a Human Resources or Personnel Department? ☐ Yes ☐ No
If no, please provide details on the handling of this function on a separate page.

b. How many **Employees** are in this department? _____
Is it centralized? ☐ Yes ☐ No

c. Does the **Insured** require that all employment terminations be reviewed prior to discharge by (check all that apply):

Human Resources Department?	☐ Yes	☐ No
Legal Department?	☐ Yes	☐ No
Outside Employment Counsel?	☐ Yes	☐ No

d. What outside legal counsel does the **Insured** use for employment and/or labor advice and/or representation?
_____

e. Does the **Insured** use an employment application for all applicants for employment? ☐ Yes ☐ No
If no, which applicants are not required to complete an application and how is the screening/hiring process conducted?
_____

f. Does the **Insured** utilize a standardized written employment offer to all applicants? ☐ Yes ☐ No
If no, which applicants are not provided with written employment offer letters and why not?
_____

g. Does the **Insured** test for any of the following:

Drug/alcohol screening	☐ Yes	☐ No
Physical examinations	☐ Yes	☐ No
Psychological examinations	☐ Yes	☐ No
Skills Testing	☐ Yes	☐ No
Polygraph Testing	☐ Yes	☐ No

If answered yes to any of the above, please attach a copy of any written policies and procedures.
Who conducts the testing? _____
Are the above tests and examinations conducted pre-employment or post-offer of employment? _____
Are all **Employees** subject to these tests? ☐ Yes ☐ No
If no, which **Employees** are not subject to these tests and/or examinations and explain why they are not subject.
_____

h. Does the **Insured** have a formal orientation program for all new **Employees**? ☐ Yes ☐ No
If yes, is an orientation checklist maintained for all new **Employees**? ☐ Yes ☐ No

i. Does the **Insured** have an **Employee** handbook? ☐ Yes ☐ No
If yes, is the handbook distributed to all **Employees**? ☐ Yes ☐ No
Do all **Employees** provide a written acknowledgement that they have received the handbook? ☐ Yes ☐ No
Is the **Employee** handbook uniform at all locations and subsidiaries? ☐ Yes ☐ No
Has an employment attorney reviewed the **Employee** handbook? ☐ Yes ☐ No
When was the **Employee** handbook last reviewed by an employment attorney? _____

j. Does the **Insured** provide annual written performance evaluations to all **Employees**? ☐ Yes ☐ No
If no, please explain_____

k. Is the **Insured** required to file an affirmative action plan with the Office of Federal Contract Compliance Programs (OFCCP)? ☐ Yes ☐ No
Has the **Insured** ever been subject of an OFCCP audit or investigation, that resulted in a finding of a violation? ☐ Yes ☐ No
If yes, please attach a copy of the audit or investigation report, the **Insured's** response to the report and any documentation disclosing actions the **Insured** has taken to remedy the violation.

l. Does the **Insured** utilize arbitration for employment-related **Claims**? ☐ Yes ☐ No
If yes, is it mandatory? ☐ Yes ☐ No
If yes, please provide a copy of the arbitration policy

m. Does the **Insured** conduct standardized exit interviews when an **Employee** resigns or is terminated (voluntary and involuntary)? ☐ Yes ☐ No
Are exit interviews documented? ☐ Yes ☐ No
Does the **Insured** have a formal out-placement program that assists terminated or laid-off **Employees** in finding other jobs? ☐ Yes ☐ No

n. Does the **Insured** conduct training on sexual harassment, harassment and discrimination prevention? ☐ Yes ☐ No
Who is required to attend?_____
Who conducts the training?_____
How often is training conducted? _____
Is the training documented? ☐ Yes ☐ No

o. Does the **Insured** conduct other management training? ☐ Yes ☐ No
If yes, please describe: _____

p. Does the **Insured** have formal written policies or procedures regarding:

1)	the handling of **Employee** complaints of discrimination or harassment	☐ Yes	☐ No
2)	the investigation of **Employee** complaints of discrimination or harassment	☐ Yes	☐ No
3)	AIDS or assisting an **Employee** with life threatening or communicable diseases	☐ Yes	☐ No
4)	**Employee** discipline and/or progressive discipline	☐ Yes	☐ No
5)	The Family and Medical Leave Act	☐ Yes	☐ No
6)	Americans with Disabilities Act / reasonable accommodation(s)	☐ Yes	☐ No
7)	Military Leave / USERRA	☐ Yes	☐ No
8)	Sexual Harassment and all other forms of harassment	☐ Yes	☐ No
9)	Discrimination and all forms of discrimination	☐ Yes	☐ No
10)	**Employee** hotline to report discrimination, harassment or other workplace issues	☐ Yes	☐ No
11)	At-Will Employment	☐ Yes	☐ No
12)	Equal Employment Opportunity	☐ Yes	☐ No

If you answered yes to any of the above, please provide copies of all such policies or details regarding such procedures.

q. Does the Applicant have a formal job posting policy? ☐ Yes ☐ No
Are all jobs posted internally? ☐ Yes ☐ No
If no, please explain _____

12. CORPORATE HISTORY

a. Has the **Insured** in the past 36 months completed, agreed to, or contemplated the occurrence within the next 18 months of, any of the following:
1) Merger, acquisition or consolidation with another entity? ☐ Yes ☐ No
If yes, please provide details.
2) Sale, distribution or divestiture of any assets resulting in a reduction of the total number of **Employees** of the **Insured**? ☐ Yes ☐ No
3) Anticipated any plant, facility, branch or office closing, consolidation or layoff? ☐ Yes ☐ No
If yes to questions 12 a. 2) or 3) above, please complete *Supplement IV: Reduction in Workforce Questionnaire*

b. Has the **Insured** been involved in any bankruptcy proceeding, or is it contemplating the filing of a petition for protection under the bankruptcy code? If yes, please provide details. ☐ Yes ☐ No

c. Has the **Insured** converted or does the **Insured** plan to convert its traditional pension plan to a cash balance plan? ☐ Yes ☐ No

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

13. CLAIMS HANDLING PROCEDURES

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): _____Email Address: _____

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): _____Email Address: _____

THIS APPLICATION WILL ONLY BE PROCESSED IF THE FOLLOWING APPLICABLE INFORMATION IS INCLUDED. FAILURE TO INCLUDE THE APPLICABLE 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. ☐ most recent annual report
b. ☐ latest **Employee** handbook and copies of any written employment at will, open door, discrimination, harassment/sexual harassment, ADA /reasonable accommodation, Family and Medical Leave, severance, progressive discipline, grievance policies and procedures including termination and/or exit interview forms
c. ☐ copies of all employment application forms currently utilized as well as specimen offer letters
d. ☐ copies of **Employee** reduction in workforce, termination and out-placement procedures
e. ☐ organizational chart that depicts where the Human Resource function exists
f. ☐ details on any performance appraisal or interview training
g. ☐ supervisory manual(s)
h. ☐ **Employee** performance form(s)
i. ☐ EEO-1 reports for the past three (3) years
j. ☐ resume/biography of the Director of Human Resources

In addition, any and all information filed with the Securities and Exchange Commission or public records may be obtained by the Insurer via the Internet, utilized in the underwriting process, and form a part of the Application. Additional information may be required as part of the Application process.

THE UNDERSIGNED DECLARES ON BEHALF OF THE APPLICANT THAT HE/SHE IS AUTHORIZED BY THE APPLICANT TO SIGN THE APPLICATION, AND THAT STATEMENTS SET FORTH IN THIS APPLICATION AND IN ALL ATTACHMENTS HERETO, ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE 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 "EFFECTIVE 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 CONTRACT, 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.

The undersigned authorized officer of the Applicant hereby acknowledges that:

1. This policy applies to **Claims** first made or deemed made, during the **Policy Period** or extending reporting period, if purchased, and
2. The Limit of Liability available to pay damages or settlements will be reduced, and may be completely exhausted, by the payment of **Claim Expenses**, and in such event, the Insurer shall not be responsible for the continued **Claim Expenses** or for the amount of any judgment or settlement to the extent that any of the foregoing exceed any applicable Limit of Liability.

FRAUD WARNING STATEMENTS

ARKANSAS APPLICANTS: 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.

COLORADO APPLICANTS: 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

DISTRICT OF COLUMBIA APPLICANTS: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

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.

HAWAII APPLICANTS: FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH.

KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH 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 ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

LOUISIANA APPLICANTS: 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.

MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NEW MEXICO APPLICANTS: 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 CIVIL FINES AND CRIMINAL PENALTIES.

OHIO APPLICANTS: 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.

OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION OR; (2) FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT MAY BE VIOLATING STATE LAW.

PENNSYLVANIA APPLICANTS: 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 SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

PUERTO RICO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURANCE COMPANY PRESENTS FALSE INFORMATION IN AN INSURANCE APPLICATION, OR PRESENTS, HELPS, OR CAUSES THE PRESENTATION OF A FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS OR ANY OTHER BENEFIT, OR PRESENTS MORE THAN ONE CLAIM FOR THE SAME DAMAGE OR LOSS, SHALL INCUR A FELONY AND, UPON CONVICTION, SHALL BE SANCTIONED FOR EACH VIOLATION WITH THE PENALTY OF A FINE OF NOT LESS THAN FIVE THOUSAND (5,000) DOLLARS AND NOT MORE THAN TEN THOUSAND (10,000) DOLLARS, OR A FIXED TERM OF IMPRISONMENT FOR THREE (3) YEARS, OR BOTH PENALTIES. IF AGGRAVATED CIRCUMSTANCES PREVAIL, THE FIXED ESTABLISHED IMPRISONMENT MAY BE INCREASED TO A MAXIMUM OF FIVE (5) YEARS; IF EXTENUATING CIRCUMSTANCES PREVAIL, IT MAY BE REDUCED TO A MINIMUM OF TWO (2) YEARS.

RHODE ISLAND APPLICANTS: "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."

TENNESSEE APPLICANTS: 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 APPLICANTS: 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.

VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

WASHINGTON APPLICANTS: 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."

WEST VIRGINIA APPLICANTS: 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.

NEW YORK APPLICANTS: 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."

NOTE: BOTH SIGNATURE LINES MUST BE COMPLETED.

Date	Applicant's Authorized Signature of Chairperson, President, or Chief Executive Officer	Title
	Please Print Name	

Date	Applicant's Authorized Signature of the **Executive Officer** in Charge of the Human Resources Department (or equivalent position)	Title
	Please Print Name	

Name of Broker: _____

Name of Agency: _____

Address: _____

_____

Signed: _____

_____

PLEASE SUBMIT THIS PROPOSAL AND APPROPRIATE MATERIALS TO:

Hartford Financial Products
2 Park Avenue, 5th Fl.
New York, NY 10016

THE HARTFORD

SUPPLEMENT I: THIRD PARTY CLAIM QUESTIONNAIRE

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? _____

(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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SUPPLEMENT II: FOREIGN OPERATIONS EXPOSURE QUESTIONNAIRE

(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?)

_____

(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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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 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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SUPPLEMENT III - REDUCTION IN WORKFORCE QUESTIONNAIRE

(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

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? _____