



INCLUDES THIRD-PARTY DISCRIMINATION COVERAGE

THIS IS AN APPLICATION FORM FOR A CLAIMS MADE POLICY

INSTRUCTIONS:

1. Answer all questions (if not applicable, show N/A) and attach all additional information/explanations as required.
2. Applications must be dated and have two signatures.
3. "Applicant" refers to the company, its predecessors, and all proposed Insureds, including Subsidiaries.

I. General Information

A. Name and address of Applicant: _____

B. Person to contact: _____
(name, title, telephone)

C. Corporation Professional Corporation Partnership Other (Please specify) _____
N.A.I.C Code or SIC Code (If N.A.I.C Code is Unknown) _____

D. Describe nature of the Applicant's business: _____

E. Number of other locations (indicate states/countries): _____

F. Does the Applicant seek coverage for Subsidiaries (50% or more owned and wholly controlled by the entity identified in "A" above)? Yes No
(If Yes, please identify Subsidiaries on a separate sheet and all Application information should include information for each Subsidiary)

G. How long has the Applicant been in business? _____ Years

H. How long has the Applicant been under current management? _____ Years

I. In the past twelve (12) months, has your total number of employees decreased by more than ten percent (10%) or five (5) employees, whichever is **greater**, through any reduction in force, systematic lay-off or by closure of any division, office or facility that you own or operate?

J. Yes No
(If Yes, please complete the Reduction In Force supplement (I))

J. In the next twelve (12) months, do you anticipate the total number of your employees to decrease by more than ten percent (10%) or five (5) employees, whichever is **greater**, through any reduction in force, systematic lay-off or by closure of any division, office or facility that you own or operate? Yes No
(If Yes, please complete the Reduction In Force supplement (J))

K. If, during the next 12 months, circumstances of which you are currently unaware make it necessary for you to decrease the number of your Employees by ten percent (10%) or five (5) Employees, whichever is greater, through the implementation of any reduction in force, systematic lay-off or by closure of any division, office or facility that you own or operate (with any such reduction, lay-off or closure not known, anticipated or planned by you as of the date of this Application), do you agree that you will consult with, and adopt the advice of, a lawyer who specializes in labor and employment law (may include in-house counsel, but only if that counsel is qualified and experienced in the practice of labor and employment law) as respects the implementation of such reduction, lay-off or closure?

Yes No

L. Does the Applicant anticipate any merger, acquisition, or addition of any operations that would comprise a twenty five percent (25%) or ten (10) employees, whichever is **greater**, increase over the current number of employees?
(If Yes, please provide full details on a separate sheet)

Yes No

M. Has the proposed coverage ever been purchased before, whether specifically or as a part of or addition to another coverage?

Yes No

<u>Year</u>	<u>Type of Coverage</u>	<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

N. Has any insurer ever canceled or non-renewed the Applicant or its predecessor for this type of coverage?
(If Yes, please provide details on a separate sheet)

Yes No

II. Financial Information

A. Please answer the following four (4) questions for the Insured Company, including its subsidiaries, for the most recent fiscal year end:

- i) What are the Applicant's total assets? \$ _____
- ii) What are the Applicant's total gross revenues? \$ _____
- iii) Does the Applicant currently have:

Net Income	<input type="checkbox"/>	or
Net Loss	<input type="checkbox"/>	
Amount \$	_____	
- iv) Does the Applicant currently have:

Positive Cashflow	<input type="checkbox"/>	or
Negative Cashflow	<input type="checkbox"/>	
Amount \$	_____	

B. Has an auditor in the previous two (2) fiscal years recommended a "going concern" opinion of the financial information for the Applicant?
(If Yes, please provide details on a separate sheet)

Yes No

III. Loss History

- A. Furnish details of all Wrongful Employment Practice Claims (as those terms are defined in the Policy) against the Applicant within the last 5 years. None See attached
(Please include all demands and lawsuits, as well as all charges, inquiries, investigations, grievance or other proceedings before the Equal Employment Opportunity Commission, or any other governmental agency with responsibility for employment practices.)

Total number of Claims in the last 5 years _____

PLEASE PROVIDE A FULL DESCRIPTION OF EACH CLAIM ON A SEPARATE SHEET.

- B. Does any director, officer, shareholder, principal, or employee with personnel responsibility have knowledge of any circumstances that could give rise to a Claim or in any other way suspect that a Claim may be brought? Yes No
- C. Have any losses, lawsuits, administrative proceedings, hearings or demands been made against the Applicant or any entity or person proposed for this insurance during the past five (5) years alleging violation of any **Wage and Hour Law**? Yes No
- D. Have any losses, lawsuits, administrative proceedings, governmental investigations, hearings or demands been made against the Applicant or any entity or person proposed for this insurance during the past five (5) years alleging violations of the Immigration Reform Control Act of 1986 or any other similar federal, state or local laws or regulations? Yes No

PLEASE PROVIDE A FULL DESCRIPTION OF EACH CIRCUMSTANCE ON A SEPARATE SHEET.

For example, but not by way of limitation, it would be reasonable for you to foresee that a Claim may be brought against you if a current or former employee, including officers, or an applicant for employment, has expressed dissatisfaction with the employment relationship or the employment application process by:

- i) making a formal complaint to an officer, principal, or supervisory employee of unfair employment practices;*
- ii) otherwise complaining of discrimination, harassment, or unfair treatment;*
- iii) threatening to hire an attorney; or*
- iv) asking for a severance package in excess of what was offered.*

The Applicant acknowledges that any Claims, or Claims later arising from circumstances reported, or that should have been reported, in this Section II will be excluded from coverage.

IV. Employees (including Subsidiary employee information on a separate sheet)

- A. Number of employees: Full Time: _____ Part Time: _____
- B. Salary ranges (including bonuses, dividends and commissions) Number of full time employees Number of part time employees
- | | | | |
|------------------------|---|-------|-------|
| \$ 50,000 or less | : | _____ | _____ |
| \$ 50,001 to \$100,000 | : | _____ | _____ |
| \$100,001 and over | : | _____ | _____ |

- C. Does the Applicant use seasonal or temporary employees? Yes No
 If so, when and how many? _____
 Are these employees included in A and B above? Yes No
- D. Does the Applicant use leased workers? Yes No
 If yes, how many have been retained by the Applicant in the past 12 months? _____
 Are these employees included in A and B above? Yes No
- E. Does the Applicant use independent contractors? Yes No
 If Yes, how many work solely for the Applicant? _____
- F. How many employees are covered by collective bargaining or other union agreements? _____
- G. In the past 12 months, how many officers have left your employ? _____
 Of the above, how many were terminated? _____
- H. In the past 12 months, how many other employees have left your employ? _____
 Of the above, how many were terminated? _____

V. Human Resources

- A. Does the Applicant have written employment agreements with all officers? Yes No
- B. Have the Applicant's managers and/or supervisors attended training and education programs/seminars on sexual harassment and other types of discrimination within the last 12 months? Yes No
 If Yes, who has attended? _____
 If Yes, who conducts the sessions? _____
- C. Does the Applicant have its employment policies/procedures reviewed by labor or employment counsel? Yes No
 If Yes, identify the firm and date of last review: _____
- D. Does the Applicant have a Human Resources or Personnel Department? Yes No
 If No, who handles this function _____
- E. Does the Applicant have an employee handbook? Yes No
 If Yes, does the Applicant distribute it to all employees? Yes No
 If Yes, do all employees sign for its receipt? Yes No
 If Yes, does it expressly state that it is not a contract and that employment is "at will"? Yes No
- F. Does the Applicant have written procedures for handling employee complaints of discrimination and/or sexual harassment? Yes No

- G. Does the Applicant require all terminations to be reviewed by:
 The person in charge of human resources? Yes No
 Outside counsel? Yes No
- H. Does the Applicant maintain a personnel file for each employee? Yes No

VI. Third-Party Information

- A. Estimated number of employees with customer/client contact: _____
- B. Has the Applicant or its predecessors ever received a complaint, formal or informal, from a non-employee, such as a customer, client, or prospective customer or client complaining about discrimination or harassment by the Applicant or any employee of the Applicant? Yes No
(If Yes, please provide details on a separate sheet)
- C. Does the Applicant conduct staff training on client and customer relations issues such as avoiding discriminatory behavior? Yes No
- D. Are there procedures for reporting and dealing with complaints by customers/clients? Yes No
- E. Is the Applicant in compliance with Title III of the Americans with Disabilities Act (building and premises requirements)? Yes No

VII. Privacy Violation Coverage

Please note that this supplement and warranty is in respect of the above new coverage extension only. Answering these questions is not a guarantee of coverage.

1. Do you restrict employee access to employees' personal information such as social security numbers, account information and health care information? Yes No
2. Are you aware of any actual or alleged fact, circumstance, situation, error or omission or issue which might give rise to a claim against you for invasion or interference with rights of privacy, wrongful disclosure or personal information, or which might otherwise result in a claim against you with regard to the insurance sought? If yes, please give details. Yes No

Details:

VIII. Other Material Facts

- A. Please declare any other Material Facts on a separate sheet. None See attached
 (If there are no other Material Facts, please check "None")

A Material Fact is one likely to influence assessment of this risk, the premium charged or the terms and conditions imposed by Underwriters. If you are in any doubt as to whether a fact would be considered material, you should disclose it. All the information requested in this proposal is material.

Please also ensure that any additional information is attached where applicable.

The Applicant warrants after full investigation and inquiry that the statements set forth herein are true and include all material information.

The Applicant on behalf of all proposed Insureds further warrants that if the information supplied on this application changes between the date of this application and the inception date of the Policy, it will immediately notify Underwriters of such change. Signing of this application does not bind Underwriters to offer, nor the Applicant to accept, insurance, but it is agreed that this application shall be the basis of the insurance and will be attached and made a part of the Policy should a policy be issued.

_____ Date _____ Signature of Applicant's Authorized Principal or Officer _____ Title

_____ Date _____ Signature of Applicant's Authorized Human Resources Representative _____ Title

(PLEASE NOTE THAT BOTH DATED SIGNATURES ARE REQUIRED)

SUPPLEMENTAL CLAIM INFORMATION

Claimant(s): _____
 Position/Title(s): _____
 Defendant(s): _____
 Position/Title(s): _____

Claim status: Incident Claim Suit

Venue:
 (Court or Agency) _____

Date of act(s) causing claim / incident: _____

Date claim / incident reported to the applicant: _____

Nature of Claim and allegations:

Name of defense attorney and law firm: _____

Name of plaintiff attorney and law firm: _____

If Closed, total paid (defense and loss): _____

If Open:

1. Claimant's demand: _____

2. Insurer's defense and/or loss reserves: _____

3. Defense costs incurred to date: _____

4. Applicant's settlement offer: _____

5. Applicant's estimate of settlement: _____

Remedial action taken to prevent a similar claim:

Reduction In Force Supplement (I)

A. How many employees were laid off? _____

B. What date(s) did the lay-off's take place? _____

C. Did you consult with and follow the recommendations of a lawyer who specializes in labor and employment law as respects the implementation of such reduction, lay-off or closure?
 Yes No

D. Were severance packages offered to all laid-off employees? Yes No

E. Were signed releases gained from all laid-off employees? Yes No

F. Were exit interviews completed with all laid-off employees? Yes No

G. Did any of the laid off employees express that they were considering bringing any sort of complaint or claim?
 Yes No

H. Please provide available details on the above.

Reduction In Force Supplement (J)

- A. How many employees will be laid off? _____
- B. What date(s) will the lay-off be effective? _____
- C. Do you agree to consult with and follow the recommendations of a lawyer who specializes in labor and employment law as respects the implementation of such reduction, lay-off or closure? Yes No
- D. Will severance packages be offered to all laid-off employees? Yes No
- E. Will signed releases be gained from all laid-off employees? Yes No
- F. Will exit interviews be completed with all laid-off employees? Yes No
- G. Please provide available details on the above.