

**WEXFORD UNDERWRITING MANAGERS, INC. d.b.a.
PROFESSIONAL RISK CO.**

**EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION
FIREMAN'S FUND INSURANCE COMPANY**

NOTICE: This is an application for a Claims Made Policy. The Policy for which application is made, subject to its definitions, terms, conditions, warranties and exclusions applies only to claims first made during the Policy Period and reported as soon as practicable thereafter (but not later than 60 days following the end of the Policy Period.) The limit of insurance available to pay damages or settlements shall be reduced by amounts incurred as defense costs.

Name of the Applicant: _____

2. Principal address: _____

City: _____ State: _____ Zip Code: _____

3. Show all locations: _____ Fax Number: _____

Name	Location	Full Time Employees	Part Time Employees	Seasonal Employees
1) (Same as Above)	(Same as Principal Address Above)			
2)				
3)				
Total Employees:				

4. Business Operations: _____ Date Established _____

5. Annual Revenue past three years: 19__ _____; 19__ _____; 19__ _____

6. Business Form: Corporation: _____ Partnership: _____ Individual: _____ Other: _____

7. List all claims involving allegations of Wrongful Termination, Discrimination, or Sexual Harassment during the past 5 years. *These should include claims involving employees, independent contractors, customers/clients, or other third parties.* If there have been no such claims, please print "None":

Date of Claim	Claimant	Nature of Claim	Defense Costs	Indemnity Costs	Status

8. Is the Applicant, its officers or senior administrative personnel aware of any fact, circumstance, incident, or situation which may reasonably be expected to give rise to a claim within the scope of the proposed policy? _____. If yes, please explain on a separate piece of paper.

9. In the past 5 years, has the Applicant been involved in any charges, inquiries, investigations, grievances or administrative hearings before any of the below agencies and/or or in regards to any of the acts listed below:

National Labor Relations Board	Yes ___ No ___	U.S. Department of Labor	Yes ___ No ___
Equal Employment Opportunity Commission	Yes ___ No ___	Americans with Disabilities Act	Yes ___ No ___
Fair Labor Standards Enforcement Act	Yes ___ No ___	Age Discrimination in Employment Act	Yes ___ No ___
Title VII of the Civil Rights Act of 1964	Yes ___ No ___	Americans with Disabilities Act	Yes ___ No ___
Civil Rights Act of 1991	Yes ___ No ___	Family Medical Leave Act	Yes ___ No ___

10. Current Employment Practices Liability Insurance information:
 Insurer: _____ Policy Inception Date: _____
 Limits: _____ Policy Expiration Date: _____
 Premium: _____ Retroactive Date: _____
11. Has the Applicant completed any merger, acquisition, or consolidation within the PRIOR 24 months?
12. Does the Applicant contemplate any merger, acquisition, or consolidation within the NEXT 24 months?
13. Has the Applicant experienced any layoffs, reductions in force, or reorganization within the PRIOR 24 months?
14. Does the Applicant anticipate any layoffs, reduction in force, or reorganization within the NEXT 24 months?
15. Number of employees under age 40: _____ Number of employees age 40 and over: _____
16. Number of employees by salary range: Under \$25,000 \$25,000-\$75,000 Over \$75,000
17. For each of the past 3 years compute the annual turn-over of employees. (Calculated as the number of separations during the year divided by the average number of employees on the payroll for each year.)
 19__ _____% 19__ _____% 19__ _____%
18. Does the Applicant have a Human Resources or Personnel Department? _____
 If so, please list the name, title, and telephone number: _____
19. Please list the name, title, and telephone number of the appropriate risk management contact for this insurance:

20. A) Does the Applicant use an employment application for all applicants for hire?
 B) Does the Applicant have an employee handbook? C) Is it distributed to all employees?
21. A) Does the Applicant have a written affirmative action plan? B) Updated in the past 12 months?
22. A) Does the Applicant have a written anti-harassment policy? _____
 B) If not, is the Applicant willing to implement a written anti-harassment policy?
23. Is there a written pay program, including pay ranges, for the organization?
24. Is there an established internal dispute resolution or grievance process?
25. Is there a written disciplinary process?
26. A) Is there a written performance appraisal process? B) Are all employees evaluated annually?
27. Are employee terminations reviewed by Human Resources? Legal Counsel?
28. Does the Applicant have written policies for Americans with Disabilities Act?
29. Does the Applicant have Federal contracts or serve as a subcontractor on contracts over \$50,000 per year?

POLICY TERMS REQUESTED

Desired Limits: \$1,000,000 per claim limit / \$2,000,000 total limit, \$2M/\$2M, \$3M/\$3M, \$4M/\$4M, \$5M/\$5M

Desired Deductible: \$2,500 ___ \$5,000 ___ \$7,500 ___ \$10,000 ___ \$15,000 ___ \$20,000 ___ \$25,000 ___

Desired Retroactive Date: _____

Desired Effective Date: _____

Third Party Liability Coverage Quotes: Yes _____ No _____

Please Attach: EEO-1 Report (If 100 or more employees);
 Supplemental information to any of the above questions.

RISK MANAGEMENT SERVICES

The proposed insurance policy is designed for preferred risks that maintain approved human resource risk management services. Should a policy be issued, the insurance agreement contemplates the concurrent and continued existence of approved human resource risk management services. The Applicant agrees to maintain these risk management services for the term of the insurance policy.

The approved risk management services must include an audit of the Applicant's human resource practices and pertinent management practices. The audit report and recommendations, if any, will be furnished to the Applicant and to the Insurance Company.

ADDITIONAL INFORMATION

For the purposes of this application, the undersigned authorized agent of the Applicant proposed for this insurance declares that to the best of her/his knowledge the statements herein are true and complete. The signing of the application does not bind the insurance carrier to provide coverage.

It is agreed that any claim(s) arising from any facts, circumstances or situations disclosed in this application are excluded from coverage. The undersigned agrees that this application and attachments will become part of and the basis for coverage, if issued.

This application must be signed by the President, Chairperson, or Executive Director of the Applicant and must be signed and dated no more than 45 days prior to the effective date of coverage.

WARNING: ANY PERSON WHO KNOWINGLY AND WITH THE 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, IS SUBJECT TO CRIMINAL AND CIVIL LIABILITY UNDER STATE AND/OR FEDERAL LAW.

SIGNED: _____ DATE: _____

PRINT NAME AND TITLE: _____
(President, Chairperson or Executive Director)

SIGNED: _____ DATE: _____

PRINT NAME AND TITLE: _____
(Human Resource/Personnel Officer)

SIGNED: _____ DATE: _____
(Producer)

PRINT NAME: _____

ADDRESS: _____
