



## Employment Practices Liability Insurance Renewal Application

*This policy is issued on a Claims Made Basis*

1. Name of Employer Applicant: \_\_\_\_\_
2. Address \_\_\_\_\_
3. City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Tel. ( ) \_\_\_\_\_
4. Business of Employer Applicant: \_\_\_\_\_
5. Have there been any changes with respect to subsidiary operations or corporations included as additional insureds?  
 Yes  No (If yes, please attach full details.)
6. Have you acquired or merged with any companies or have you been acquired by another company in the last year?  Yes  No
7. Have you made any changes in the employment application in the past year?  Yes  No  
 (If yes, please attach a copy.)
8. Have you made any revisions to the employee handbook/policies manual in the past year?  Yes  No  
 (If yes, please attach copy of changes.)

9. Please complete the following:

For 12 months ending: \_\_\_\_\_

Total Assets: \$ \_\_\_\_\_ Revenues: \$ \_\_\_\_\_

Working Capital: \$ \_\_\_\_\_ Net Income: \$ \_\_\_\_\_

Long Term Debt: \$ \_\_\_\_\_

Net Worth: \$ \_\_\_\_\_

10. Race and Sex of work force for all entities proposed for insurance: \_\_\_\_\_%Male \_\_\_\_\_%Female \_\_\_\_\_%White  
 \_\_\_\_\_% Black \_\_\_\_\_%Hispanic \_\_\_\_\_%Asian \_\_\_\_\_%American Indian \_\_\_\_\_%Other

11. A. Please complete the following Employee information reflecting the **total** number of employees by salary range:

Salary Range	Hired during past 12 months.	Voluntary Terminations Past 12 Months.	Involuntary Terminations during past 12 months.
0-25,000			
25,001-50,000			
50,001-100,000			
100,001-200,000			
200,001 +			

11. B.

Salary Range	Employed Currently Total
\$0-25,000	
\$25,001-50,000	
\$50,001-100,000	
\$100,001-200,000	
\$200,001 +	

C. Number of employees leased: \_\_\_\_\_

(These should be included within question 11B)

D. Number of seasonal or part-time employees: \_\_\_\_\_

(These should be included within question 11B)

E. Are any employees union members? \_\_\_ Yes \_\_\_ No

How many? \_\_\_\_\_

12. Does the Employer Applicant, or any of those subsidiaries included as additional insureds, anticipate any lay-offs or reduction in staff of 20% or more in the next 18 months? \_\_\_ Yes \_\_\_ No (If yes, provide explanation)

13. Does the Insured want to renew coverage as expiring? \_\_\_ Yes \_\_\_ No

If other limits or deductibles required, please indicate Limit: \_\_\_\_\_ Deductible: \_\_\_\_\_

14. Have all known claims, lawsuits, incidents and/or charges involving (wrongful) acts of discrimination or wrongful termination been reported to U. S. Risk, Inc. or Professional Claims Managers, Inc. ? \_\_\_ Yes \_\_\_ No (If no, provide explanation)

15. None of the individuals or corporations proposed for insurance is aware of any Wrongful Act (or allegation thereof) which there is reason to believe might afford grounds for any future claim such as would fall within the scope of the proposed insurance, except as follows: (if none, so state)

\_\_\_\_\_  
\_\_\_\_\_

The undersigned authorized Officer of the Employer Applicant declares that to the best of his/her knowledge and belief the statements set forth herein are true. Although the signing of this Application does not bind the undersigned to effect Insurance the undersigned, on behalf of all individuals, partnerships and corporations proposed for insurance, agrees that this form and the said statements shall be the basis of the contract and that the Underwriters have relied on the correctness thereof, should a policy be issued and this application and any attachments shall attach to and become part of any such contract.

Arkansas Residents: 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.

Signed \_\_\_\_\_

Capacity \_\_\_\_\_

Corporation \_\_\_\_\_

Date \_\_\_\_\_

INDIVIDUAL CLAIM DATA REPORT

APPLICANT'S INSTRUCTIONS:

- 1. This form is to be completed by Applicant regarding any claim or suit during the past five (5) years or any facts, circumstances, acts, errors, or omissions of which applicant is aware which may give rise to a claim. COMPLETE ONE FORM FOR EACH SUCH CLAIM OR CIRCUMSTANCE.
- 2. If additional "Individual Claim Data Reports" are required, please photocopy blank report.
- 3. If space is insufficient to answer any question fully, attach a separate sheet.
- 4. Answer all questions completely.

(PLEASE TYPE OR PRINT)

1. Full name of Applicant:  
\_\_\_\_\_

2. Full name of individual(s) involved or named in the claim:  
\_\_\_\_\_

3. Full name of Claimant:  
\_\_\_\_\_

4. Indicate whether: Claim/suit: \_\_\_\_\_ Incident: \_\_\_\_\_

5. Date of alleged error: \_\_\_\_\_ Date of claim: \_\_\_\_\_

6. Additional defendant (if any):  
\_\_\_\_\_

7. IF CLOSED:  
Total Loss Paid including Deductible: \$ \_\_\_\_\_  
Legal Expenses Paid: \$ \_\_\_\_\_

8. IF PENDING:  
Claimant's settlement demand \$ \_\_\_\_\_ Loss reserves \$ \_\_\_\_\_  
Defendant's offer of settlement \$ \_\_\_\_\_ Loss paid to date \$ \_\_\_\_\_  
Expense reserves \$ \_\_\_\_\_ Expenses paid to date \$ \_\_\_\_\_  
Deductible \$ \_\_\_\_\_ Is claim in suit: Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes, Amount asked in summons? \$ \_\_\_\_\_

9. Name of Insurer (if any) : \_\_\_\_\_

10. Description of claim: (Provide enough information to allow evaluation and use back of this page or separate exhibit if additional space is required.)

A. Alleged act, error or omission upon which claimant bases claim:  
\_\_\_\_\_  
\_\_\_\_\_

B. Description of the type and extent or injury or damage allegedly sustained:  
\_\_\_\_\_  
\_\_\_\_\_

I understand information submitted herein becomes a part of the proposal and is subject to the same warranty and conditions.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_