



Employment Practices Liability New Business Insurance Application

Section A. General Information

1. Name of Insured: _____	
If there are other entities for which coverage under this Policy is requested, please provide their name(s) prior to binding coverage and complete the Additional Insured/Location schedule.	
2. Address of Named Insured (physical address required, no P.O. Box): _____	
3. Federal Tax Classification: C Corp <input type="checkbox"/> S Corp <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> (C Corp) <input type="checkbox"/> LLC (S Corp) <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Other: _____	4. Years in Operation: _____
5. Nature of Business: _____	6. Website: _____
7. Contact Name: _____	8. Telephone: _____
9. Fax: _____	10. Email Address: _____
11. Is your company a franchise? <input type="checkbox"/> Yes <input type="checkbox"/> No	11a. If yes, please provide the name of the franchise: _____
12. Total Number of Employees: _____ a. Full Time: _____ Part Time: _____ Seasonal: _____ Temporary: _____ Union Full Time: _____ Union Part Time: _____	
Please do not include independent contractors or leased workers in the above employee counts. See below	
13. Does your organization use Independent Contractors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If you are seeking coverage for Independent Contractors, please indicate the total number:	_____
14. Does your organization use Leased Workers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you are seeking coverage for Leased Workers, please indicate the total number and provide the name of the Leasing Firm:	
a. Number of Leased Workers: _____	b. Name of Leasing Firm: _____
15. Indicate the number of employees whose annual income is greater than \$100,000: _____	
16. Total Number of Locations: _____ (If more than one, you must fully complete the Additional Insured/Location schedule)	
17. Provide the turnover rate (%) for the past three years: <div style="display: flex; justify-content: space-around; width: 100%;"> _____ _____ _____ </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> 20 20 20 </div>	
18. If applicable, how many involuntary terminations within the past 12 months?	_____
a. Of those, how many individuals were senior managements, officers/directors or partners?	_____
19. If applicable, how many resignations of senior management/ officer/ partner within the past 12 months?	_____
20. Do you anticipate any work force reduction or lay-offs within the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section B. Human Resources

1. Does your company have a Human Resources or Personnel Department?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you train all your managers and supervisors on HR related issues, including prohibited harassment and discrimination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you adopted and implemented anti-sexual harassment policies and written procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have an EEO Statement or have you adopted and implemented anti-discrimination policies and developed written procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does your company have an Employee Handbook?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section C. Acquisitions/ Mergers/ Closures

1. Have you acquired another entity or organization, or have you had any other organizational or structural changes during the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, did you terminate any employees or officers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are there any plans to merge with or acquire any entities or organizations, or are there any plans for organizational or structural changes within the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, do you plan to terminate any employees or officers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the Organization anticipate in the next twelve (12) months or have they transacted in the last twenty four (24) months any restructuring or legal or financial reorganization or filing for corporate bankruptcy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section D. Third Party Wrongful Act Coverage

1. Do you have written procedures for handling complaints of discrimination and sexual harassment from a person other than an employee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are your facilities designed to accommodate the disabled in compliance with the Americans with Disabilities Act (ADA) of 1990 and the Americans With Disabilities Act Accessibility Guidelines (ADAAG)(collectively "ADA")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, do you anticipate that your facilities will be in compliance with ADA for the next twelve (12) months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section E. Claim History

1. As of when have you purchased uninterrupted EPL coverage?	
a. If you currently have EPL insurance which carrier:	Expiration Date:
2. Has any insurer ever cancelled or non-renewed this type of insurance? (not applicable to applicants in Missouri)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any claim, suit, complaint, charge, or other proceeding related to actual or alleged wrongful employment practices, including but not limited to sexual harassment, wrongful termination, wrongful discrimination, unfair labor practices, or wage and hour violations, been brought against your company in the last FIVE (5) years? <i>This includes, but is not limited to, any complaint or charge filed with the EEOC, state or local FEPA, or other administrative agency, any demand letter from an individual or an attorney, or any state or federal lawsuit.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, you are required to provide full details of the claim(s), including but not limited to, specific nature of the allegations, date of loss, current status, all amounts paid and or anticipated. You can use our claim supplemental or provide a detailed explanation on a separate sheet.	
4. Does any Director, Officer, Manager, Supervisor, Employee or Partner currently have knowledge of any pending Claim(s) and/or any fact(s), circumstance(s), situation(s) or event(s) which could reasonably give rise to a Claim against you for alleged employment practices by any former or current employee or a claim alleging third party discrimination or harassment, including but not limited to any alleged violations of the ADA, which could reasonably give rise to a Claim against you? <i>By way of example, but in no way limited to the following situations, we consider it reasonable for you to foresee that a claim may be brought against you if a current or former employee, applicant for employment, or customer, vendor or supplier: has made an internal complaint to a supervisory employee regarding discrimination, harassment or unfair employment practices; has threatened to hire an attorney or take other legal action against your company or organization; has requested a severance package or settlement in excess of what has been offered; or frequently complains of discrimination, harassment or unfair treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please fully complete our claim supplemental or provide a detailed explanation on a separate sheet.	

APPLICABLE IN NEW YORK:

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.

APPLICABLE IN ALABAMA:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

APPLICABLE IN COLORADO:

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 of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN THE DISTRICT OF COLUMBIA:

WARNING: 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.

APPLICABLE IN FLORIDA:

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.

APPLICABLE IN HAWAII:

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.

APPLICABLE IN KANSAS:

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN MARYLAND:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT:

Any person who knowingly and with intent to defraud any insurance company or another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

APPLICABLE IN MINNESOTA:

Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN OHIO:

Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA:

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.

APPLICABLE IN WASHINGTON and VIRGINIA:

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.

APPLICABLE IN ALL OTHER STATES:

Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and civil penalties. In LA, ME and TN, insurance benefits may also be denied.

Section F. Representations and Important Notices

The undersigned, acting on behalf of all Insureds, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each and every Insured proposed for this insurance to facilitate the proper and accurate completion of this Application.

The undersigned agree that the particulars and statements contained in the Application and any material submitted herewith are their representations and that they are material and are the basis of the insurance contract. The undersigned further agree that the Application and any material submitted herewith shall be considered attached to and a part of the Policy. Any material submitted with the Application shall be maintained on file (either electronically or paper) with the Insurer and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

- If any significant change in the condition of the applicant is discovered between the date of this Application and the Policy inception date, which would render this Application inaccurate or incomplete, notice of such change will be reported in writing to the Insurer immediately;
- Any Policy, if issued, will be in reliance upon the truth of such representations; provided, however, with respect to such statements and representations, no knowledge or information possessed by any Insureds shall be imputed to any other Insureds. If any person or persons knew as of the Policy inception date that such declarations and statements contained in the Application(s) were untrue, inaccurate or incomplete, then this Policy will be void as to that person or persons. However, if the Chairperson of the Board of Directors, President, Chief Executive Officer, or Chief Financial Officer of the Insured Entity knew as of the Policy inception date that such declarations and statements contained in the Application(s) were untrue, inaccurate or incomplete, then this Policy will be void as to that person or persons and the Insured Entity;
- This Application has been completed as respects the entire Insured Entity;
- The signing of this Application does not bind the undersigned to purchase the insurance.

Applicant's Authorized Signature of the President, Chief Executive Office, or equivalent position

Signature: _____ Date: _____

Printed Name: _____ Title: _____

When the Applicant is in New Hampshire or Florida, must also be signed by the Producer:

Producer Name: _____ Agency Name: _____

Signature of Producer: _____ Date Signed by Producer: _____

Producer License #: _____

California Fraud Warning

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYMENT PRACTICES LIABILITY INSURANCE LOCATION AND EMPLOYEE INFORMATION SCHEDULE

INSTRUCTIONS: List all locations and/or entities to be covered by the policy for which you are applying. Failure to list a particular location or entity may preclude coverage for that location or entity. Please note all locations and/or entities must have a majority ownership of 50%+ by the Named Insured to be eligible for coverage under this Policy. Any location, organization or entity that is created, formed or merged after the Effective Date of this Policy must be reported to the Company.

	Entity Name	Entity Address	Nature of Business	Employees	
				Full Time	Part Time
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
Totals					

I understand the Location and Employee Information Schedule form will become part of my organization's Employment Practices Liability Application and is subject to the same representations and conditions.