EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION—FLORIDA

THIS APPLICATION IS FOR A CLAIMS-MADE POLICY. PLEASE READ YOUR POLICY CAREFULLY

Applicant may qualify for a ***QUICK QUOTE*** by completing Section I below. Sections II, III, IV & V answers will be required prior to binding and are subject to underwriting approval.

I GENERAL INFORMATION

Quick quote is not available for accounts with losses in the past 5 years. If there is a loss history, please complete the entire application and submit details in a claim supplement.

1. Applicant/Named Insured ______________________________

2. Physical Address ***(P.O. Box is not an applicable address)*** ☐ Same as mailing address

____

City ______________ State ______ Zip ______ County ______

3. Web Address: ______________________________

4. Primary Contact Email Address ______________ Tel: (____) ______________

5. Description of Operations: ______________________________

6. Business is: ☐ Corporation ☐ Individual Proprietor ☐ Partnership ☐ LLC ☐ Other: ______________

7. Employees: Full time ________ Part time ________

Temporary/Seasonal ________ Leased: ________

Independent Contractors ________ Volunteer/Interns ________

8. What percentage of employees belong to a Union ______%

9a. Number of Locations: Within U.S. ________ Outside the U.S. ________

9b. Employees: **List Top 3 States/No. of Employees**

1. ________ / ________

2. ________ / ________

3. ________ / ________

No. of Employees Outside the U.S. ________

II UNDERWRITING INFORMATION

1. Year Established ____________ No. of years under current management ____________

2. Do more than 50% of all employees currently earn more than $100,000? . . . . ☐ Yes ☐ No

3 a. Is the Applicant a Subsidiary of another organization? . . . . . ☐ Yes ☐ No *If "Yes", please complete supplemental application.*

b. Is the Applicant a franchisee of another organization? . . . . ☐ Yes ☐ No *If "Yes", please provide the following:*

c. Name of Parent and/or Franchisor ______________________________

Location ______________________________

4. Does the Applicant want any Subsidiary(s) covered? ☐ Yes ☐ No *If "Yes," include employees in employee count above and provide:*

a. Name of Subsidiary(s) ______________________________

b. Is the Subsidiary(s) at least 50% owned by the Applicant? . . . . ☐ Yes ☐ No

c. Does the Subsidiary(s) fall within the same class of business as the Applicant? . . . . ☐ Yes ☐ No

5. Expiring Policy:

Retroactive Date ____/____/______ Limits $ ____________ Retention $ ____________ Premium $ ____________

Expiration Date ____/____/______ Carrier ______________________________

III HUMAN RESOURCES

1. Written Guideline Requirements:
   a. Does each entity proposed for Insurance have a written Email/Internet Policy currently in place or is willing to implement one? . . . . ☐ Yes ☐ No
   b. Does each entity proposed for insurance have a written Anti-Discrimination and Anti-Harassment Policy? . . . . ☐ Yes ☐ No
   c. Does the company have an employee grievance reporting and resolution process? . . . . ☐ Yes ☐ No
   d. Does the company have a HR Coordinator? . . . . ☐ Yes ☐ No *If "No", describe how HR functions are administered.*

   ____

   ____

   ____

   e. Do all employees receive training in the proper implementation of your human resources policies and procedures? ☐ Yes ☐ No
   If "Yes," please provide a description and number of hours each employees is required to take.

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   ____

   f. Do you have a written policy with respects to progressive discipline for Employees? . . . . ☐ Yes ☐ No

IV BUSINESS PRACTICES

1. a. Has any entity proposed for insurance closed, sold, merged-with or acquired any company in the past 12 months or anticipate doing so in the next 12 months? . . . . ☐ Yes ☐ No
   b. Has any entity proposed for insurance downsized, laid off, or reduced staff in the past 12 months or anticipate doing so in the next 12 months? . . . . ☐ Yes ☐ No ***If "Yes," please complete the following three questions.***
      1) What percentage of the workforce was/will be affected? __________%
      2) How and why were the individuals selected? ***Provide details on separate sheet of paper.***
      3) What will be offered—*Check all that apply:*
      ☐ **Re-location arrangements** ☐ **Re-training** ☐ **Severance package** ☐ **Out-placement**
2. Has any Policy for Employment Practices Liability Insurance ever been cancelled or non-renewed by the carrier?. . . . ☐ Yes ☐ No
3. Do you own any other entities? . . . . ☐ Yes ☐ No *If "Yes", please provide details on supplemental application.*

V CLAIMS HISTORY

1. Within the last 5 years, has any employment related, or third party discrimination, or third party harassment inquiry, complaint, notice of hearing, claim, or suit been made against any entity proposed for Insurance or any person proposed for insurance in the capacity of either Director, Officer, Member (if an LLC), or Employee of any entity proposed for Insurance?. . . . ☐ Yes ☐ No
   If "Yes," complete Claim Supplemental for each claim.
2. Is any person proposed for this Insurance aware of any fact, circumstance, or situation which may result in an employment claim, or third party discrimination, or third party harassment claim against any entity proposed for Insurance or any of its Directors, Officers, Members (if LLC), or Employees?. . . . . ☐ Yes ☐ No ***If "Yes," complete Claim Supplemental for each claim.***

VI ADDITIONAL APPLICANT INFORMATION

Applicant's Mailing Address ____

City ______________________ State __________ Zip __________

DISCLOSURE WARNING

I understand that there is no coverage for punitive damages assessed directly against an insured under Florida law. However, I also understand that punitive damages that are not assessed directly against an insured, also known as "vicariously assessed punitive damages", are insurable under Florida law. Therefore, if any Policy is issued to the Applicant as a result of this Application and such Policy provides coverage for punitive damages, I understand and acknowledge that the coverage for Claims brought in the State of Florida is limited to "vicariously assessed punitive damages" and that there is no coverage for directly assessed punitive damages.

If your state requires that we have information regarding your Authorized Retail Agent or Broker, please provide below.

Retail Agency Name ______________________________

Agent's Email ______________________________

Agent's Signature ______________________________

Agent's Name (please print) ____________________ Agent's License Number ____________

Main Agency Phone Number (_____) ____________

Agency Mailing Address ______________________________

City ____________________ State ______ Zip ____________

The signer of this application acknowledges and understands that the information provided in this Application is material to the Insurer's decision to provide the requested insurance and is relied on by the Insurer in providing such insurance. The signer of this application represents that the information provided in this Application is true and correct in all matters. The signer of this Application further represents that any changes in matters inquired about in this Application occurring prior to the effective date of coverage, which render the information provided herein untrue, incorrect or inaccurate in any way will be reported to the Insurer immediately in writing. The Insurer reserves the right to modify or withdraw any quote or binder issued if such changes are material to the insurability or premium charged, based on the Insurer's underwriting guides. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the Policy.

Fraud Warning

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.

Applicant's Signature ______________________________ Title ______________________________

President, Chairperson of the Board, Managing Member, or Executive Director

Date ____/____/______