EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION—IOWA

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.

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.

I GENERAL INFORMATION

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.

_____

_____

_____

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 _____

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

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)* _____

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.

New York Fraud Statement: 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.

Applicant's Signature _____ Title _____

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

Date ____ / ____ / _____