



Utica National Insurance Group

Insurance that starts with you.
Utica Mutual Insurance Company and its affiliated companies, New Hartford, N.Y. 13413

EMPLOYMENT - RELATED PRACTICES LIABILITY INSURANCE APPLICATION

THIS IS AN APPLICATION FOR A CLAIMS-MADE POLICY. SEE NOTICE ON PAGE 5. READ YOUR POLICY CAREFULLY.

THE POLICY INCLUDES DEFENSE COSTS IN ITS LIMITS OF INSURANCE. ANY DEFENSE COSTS PAID UNDER COVERAGE WE PROVIDE WILL REDUCE THE AVAILABLE LIMITS OF INSURANCE UNDER THAT COVERAGE AND MAY EXHAUST THEM COMPLETELY.

Named Insured: _____ Producer: _____
Mailing Address: _____ Producer No: _____
City: _____ State: _____ Zip: _____ License No: _____
Policy Period: _____ to _____

I. CORPORATE HISTORY

- 1) Describe the firm's operations:

- 2) Number of years in business? _____

- 3) Have you had any plant, facility, branch or office closings, consolidations, layoffs or staff reductions (greater than 10% of the workforce), mergers or acquisitions within the past 24 months or, do you anticipate any of the above within the next 12 months? Y N
If yes, please provide details on the supplemental application attached.

- 4) Does the organization have any contracts with or receive financial assistance from the Federal Government? Y N
If yes, please provide details on the supplemental application attached.

II. EMPLOYEES

- 5) By state, please list the total number of locations and employees, broken down by Full time employees (FT), Part time employees* (PT), Temporary/Leased workers (TL), and Independent contractors** (IC) for each of the last 3 calendar years:

1. Last Full Year (1/1 thru 12/31)						2. Last Full Year Prior to 1.					
State	Number of Locations by State	Employees				State	Number of Locations by State	Employees			
		# FT	# PT	# TL	# IC			# FT	# PT	# TL	# IC
Totals						Totals					

3. Last Full Year Prior to 2.					
State	Number of Locations by State	Employees			
		# FT	# PT	# TL	# IC
Totals					

* Defined as employees working less than 32 hours per week (1600 hours per year).

** Independent Contractors are not covered under the basic policy, but their use must be reported. If you desire coverage for potential claims by independent contractors, please use the Supplemental Application attached.

6) Percent of workforce that have been union members in the last three calendar years:
 Last _____ First Prior _____ Second Prior _____

7) Breakdown of current Full Time employees by their total cash compensation (salary + bonus):

Salary ranges	# of Employees	% of total
\$30,000 or less per year	_____	_____
\$30,001 - \$100,000 per year	_____	_____
Over \$100,000 per year	_____	_____
Total	_____	_____

8) Turnover
 Number of Full Time and Part Time employees terminating employment (whether initiated by employer or employee) during the year divided by the total at the start of the year (e.g. Total employees; at start of year = 100; Number of employees terminating employment during year = 5; 5 ÷ 100 = 5%):
 Last full calendar year _____ % Next Prior _____ % Next Prior _____ %

9) Total number of employer initiated terminations of F/T and P/T employees for last three calendar years:
 Last full calendar year _____ Next Prior _____ Next Prior _____

III. LOSS HISTORY

10) Within the last 5 years has the firm, inclusive of predecessor firms, or any individual proposed for this insurance:

- a) received any employment related inquiry, complaint or charge from any municipal, state, or federal regulatory authority or any other governmental entity? Y N
- b) had a claim, suit, grievance, or demand been brought against them? Y N

If yes to either, explain each on the supplemental application attached:

11) Are you aware of any facts, incidents, or circumstances which may result in a claim(s) being made against you? Y N

If yes, explain on the supplemental application attached.

THE APPLICANT UNDERSTANDS AND AGREES THAT IF ANY FACTS, INCIDENTS, OR CIRCUMSTANCES ARE KNOWN WHICH MAY REASONABLY GIVE RISE TO A CLAIM UNDER THIS PROPOSED POLICY, THEN ANY CLAIMS ARISING FROM SUCH FACTS, INCIDENTS, OR CIRCUMSTANCES ARE EXCLUDED FROM COVERAGE THEREUNDER. FAILURE TO DISCLOSE SUCH KNOWN FACTS, INCIDENTS OR CIRCUMSTANCES HERE WILL VOID THE PROPOSED POLICY IN ITS ENTIRETY.

IV. HUMAN RESOURCES FUNCTION

12) a. Who is responsible for the Human Resources or Personnel functions?

Name _____ Title _____

b. Who is designated to handle all employment-related incidents?

Name _____ Title _____

13) Do you make use of any of the following tests screen employment applicants, to promote employees, or for the purpose of continuing employment?

a) Psychological or personality tests: Y N

b) Drug or alcohol tests Y N

c) Pre employment offer medical tests Y N

If yes, provide details on the supplemental application attached.

V. INSURANCE INFORMATION

14) Do you currently carry Employment-Related Liability Insurance?

If yes, please provide: Y N

Insurer: _____

Limit: _____ Per Claim: _____ Aggregate: _____

Policy Period: _____ Retroactive Date: _____

Retention or Deductible: _____ Co-Insurance Amount: _____

Premium: _____

15) Has any insurer ever canceled or non-renewed this type of coverage? Y N

If yes, provide details on the supplemental application attached.

16) Current GL carrier? _____

Limit of Liability _____

17) Check desired limits of liability (per claim/aggregate):

\$500,000/\$500,000

\$1,000,000/\$1,000,000

\$2,000,000/\$2,000,000

18) Check desired:

a) Retention (per claim) \$5,000 (basic) \$10,000 \$25,000

b) Co-insurance Participation (per claim)

0% (basic)

5% (with \$25,000 per claim max)

5% (with \$50,000 per claim max)

10% (with \$25,000 per claim max)

10% (with \$50,000 per claim max)

VI. RISK MANAGEMENT PRACTICES

19 a) Have all your employment related policies and procedures been reviewed and approved by outside counsel? Y N

If yes, when? _____

By whom? Firm: _____ Atty: _____

Does this firm, or attorney used for review, specialize in employment law? Y N

b) Have all recommendations from that review been implemented? Y N

If not, explain or provide time frame for implementation on supplemental application attached.

20) Do you use an employment application during your hiring process? Y N

If yes, does it contain:

a. An employment at will statement? Y N

b. Authorization to check references & criminal conviction records? Y N

c. The applicant's signature attesting that all representations are true? Y N

d. An equal employment opportunity statement? Y N

21) Do you distribute an employment handbook to your employees? Y N

If yes, does it contain:

a. an employment at will statement? Y N

b. a written equal employment opportunity statement? Y N

c. a written anti-sexual and general harassment policy? Y N

d. a written internal complaint procedure for discrimination and sexual harassment claims? Y N

If no, do you have written policies on all of the above that are distributed separately? Y N

Specify any that are not:

22) Do you have a progressive disciplinary program? Y N

If yes, is it distributed to supervisors in writing? Y N

23) Do you post, in places conspicuous to all employees and applicants for employment, all notices required by law? Y N

24) When requested by employees, do you distribute information as required by federal law regarding the Family Medical Leave? Y N

25) Do you require that all employment terminations be reviewed by the personnel having human resources responsibilities? Y N

26) Have you informed supervisory personnel, in writing, of their responsibility to provide you with prompt notice of any claims, incidents or allegations? Y N

VII. ADDITIONAL INFORMATION

Please attach each of the following, if they exist:

- Employee handbook
- Employee grievance, disciplinary, termination, and out-placement procedures
- Employment application Form(s)
- EEO and Discrimination and Sexual Harassment Policy
- Separation Agreement Form

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE UNDERSIGNED FURTHER DECLARES THAT ANY CLAIM, INCIDENT OR EVENT TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WHICH MAY RENDER INACCURATE, UNTRUE, OR INCOMPLETE ANY STATEMENT MADE WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

THE FIRM UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY BE ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY.

THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THIS REPRESENTATION, ON BEHALF OF THE FIRM OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.

THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE. IT IS AGREED, HOWEVER, THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT AND IS BEING RELIED UPON BY THE COMPANY SHOULD A POLICY BE ISSUED. IF A POLICY IS ISSUED, THIS APPLICATION WILL BE DEEMED ATTACHED TO AND MADE A PART OF THE POLICY, WHETHER PHYSICALLY ATTACHED OR NOT.

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 a an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signatures of:

Sole Proprietor, Partner, Manager (if Limited Liability Company), or President or Chairman (if Corporation):

Dated: _____

Individual responsible for Human Resources function: _____

Dated: _____

NOTE: The attached Supplemental Application must be completed if you have provided any "yes" responses to questions 3, 4, 10, 11, 13, 15 or 19 above or if you are interested in coverage for independent contractors.

Supplemental Application

- 3) Details of plant, facility or branch office closings, consolidations, layoff/staff reductions (greater than 10% of the workforce), mergers or acquisitions within the past 24 months

Details on any of the above anticipated in the next 12 months

- 4) Description of contracts with the Federal Government, including revenue size and any financial assistance.

Is there an affirmative action plan?

Y

N

If yes, please attach a copy and describe reason for implementing.

- 5) Details of all independent contractor contracts for which you would want coverage under this insurance for claims brought by such contract workers. Include number of workers, type of work, approximate average hours/week and/or months of use, and whether workers are primarily on site or off.

- 10) a. Details of any employment-related inquiry, complaint, charge, from any municipal, state, or federal regulatory authority or any other governmental entity within the last 5 years: (Provide date, complete description, amount demanded, and amount paid and/or reserved.)

- b. Details of any claim, suit, grievance, or demand within the last 5 years:
(Provide date, complete description, amount demanded, and amount paid and/or reserved.)

- 11) Details of any facts, incidents, or circumstances which may result in a claim(s) being made against you:

13) Tests used to screen employment applicants, to promote employees, or for the purpose of continuing employment.

Describe:

- a) type of test;
- b) how the test is administered, i.e.: to all employees or segments of, please detail procedures; and
- c) Company creating test and validation documentation.

15) Details of canceled Employment-Related Practices Liability Insurance:

Carrier: _____ Cancellation Date: _____
Reason: _____

19) Explain any recommendations made by outside counsel which have not been implemented, and reason why or timeframe to complete.