



APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE FOR ACCOUNTING FIRMS

NOTICE: THE POLICY FOR WHICH APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS, ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD," OR, IF PURCHASED, ANY EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED BY "DEFENSE EXPENSES," AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION. THE UNDERWRITER WILL HAVE NO DUTY TO DEFEND ANY "CLAIM." READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

1. GENERAL INFORMATION

A. Name of **Applicant**: _____
Address: _____
City: _____ State: _____ ZIP _____

B. Date of organization: _____

C. List all locations or branch offices by city and state (include approximate number of employees at each location). Please use a separate addendum if necessary.

Locations or Branch Offices	Approximate Number of Employees
_____	_____
_____	_____
_____	_____
_____	_____

D. List prior employment practices liability insurance for the past three (3) years (either stand-alone policies or supplemental coverage provided under some other type of insurance). Please use a separate addendum if necessary.

Period	Insurer	Limit	Retention	Coinsurance	Premium
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

E. Has a previous insurer ever canceled or non-renewed the **Applicant** for employment practices liability insurance (either on a stand-alone basis or as supplemental coverage provided under some other type of insurance)? (Not applicable in Missouri.) Yes No

If "Yes," provide details of the circumstances of cancelation or non-renewal.

F. Desired coverage: Limit of liability: _____ Retention: _____
Coinsurance (if other than 10%): _____

2. EMPLOYEES

- A. Current number of Partners: _____
 All other full-time employees: _____
 Part-time employees (including seasonal and temporary): _____
- B. What was the annual employee (including all professionals) turnover rate for the last four (4) years?
 19____: ____% 19____: ____% 19____: ____% 19____: ____%
- C. How many involuntary terminations have occurred in the past two (2) years?
 Employees: _____ All professionals: _____
- D. Percentage of employees (including all professionals) with salaries (including bonuses):
 Less than \$50,000: _____%
 \$50,000 - \$100,000: _____%
 \$100,000 - \$250,000: _____%
 Greater than \$250,000: _____%

3. LOSS HISTORY

- A. Please provide a listing of all employment practices claims over the past three (3) years, including information regarding the type of claim; the parties involved; and any settlement or final determination of the claim. If none, so state. Please use a separate addendum if necessary.

- B. Please provide a listing of any facts or circumstances which may result in employment practices claims being made against the **Applicant**. If none, so state. Please use a separate addendum if necessary.

- C. Has the **Applicant** ever been involved in any grievance or administrative hearing before the following agencies or under any of the following Acts:

1. National Labor Relations Board	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Equal Employment Opportunity Commission	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Civil Rights Act of 1991	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Age Discrimination in Employment Act	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Americans With Disabilities Act	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Any other Governmental Agency or Act	<input type="checkbox"/> Yes	<input type="checkbox"/> No

 If "Yes," please provide details. Please use a separate addendum if necessary.
- D. Does the **Applicant** utilize any form of alternative dispute resolution? Yes No
 If "Yes," please describe on a separate addendum.

4. HUMAN RESOURCES

- A. Does the **Applicant** have a human resources department? Yes No
- B. Provide the name of the head of this department and the total number of employees therein.
 Name: _____ Total number of employees: _____

C. How are human resources matters handled in branch offices? Please use a separate addendum if necessary.

D. Does the **Applicant** have written procedures in place with regard to the following:

- | | | |
|----------------|------------------------------|-----------------------------|
| 1. Termination | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Hiring | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Discipline | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

E. Is there an employee handbook?

Yes No

If "Yes":

- | | | |
|--|------------------------------|-----------------------------|
| 1. Is it distributed to all new employees (including all professionals)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does it contain a comprehensive "employment at will" statement? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

F. Is there a written procedure for handling employee complaints of harassment and/or discrimination?

Yes No

G. Have anti-sexual harassment policies and procedures been implemented by the **Applicant**?

Yes No

If "Yes," has the **Applicant** informed employees that incidents of sexual harassment may be reported without fear of retaliation by the **Applicant**?

Yes No

H. Does the **Applicant** use any tests to screen applicants either for hire or promotion?

Yes No

If "Yes," please provide details. Please use a separate addendum if necessary.

I. Are all prospective employees required to complete an employment application prior to hire?

Yes No

J. Is there a formal orientation program for new employees?

Yes No

K. Are regular, written performance evaluations completed for and provided to all employees?

Yes No

L. Does the **Applicant** anticipate any branch/location closings, consolidations, or layoffs?

Yes No

If "Yes," please provide details including the year, anticipated number of layoffs, and the circumstances surrounding those layoffs. Please use a separate addendum if necessary.

M. Does the **Applicant** have a formal out-placement program which assists former employees in obtaining alternate employment?

Yes No

N. Does the **Applicant** require terminations to be reviewed by outside counsel in addition to its human resources department?

Yes No

O. Is there a policy concerning assistance provided to employees with AIDS or any other life-threatening or communicable diseases?

Yes No

5. FIRM HISTORY

If the **Applicant** answers "Yes" to any of the following questions, please provide further details on a separate addendum.

- A. Has the **Applicant** acquired any other entities in the last ten (10) years? Yes No
- B. If "Yes" to Question (5. A.), did the acquisition include the assumption of liabilities? Yes No
- C. With respect to any acquisitions, were any employees, partners, or other professionals terminated, or does the **Applicant** plan in the next eighteen (18) months to terminate any employees, partners or other professionals? Yes No

6. PLEASE PROVIDE COPIES OF THE FOLLOWING:

- A. Firm Financial Information Supplement (Attachment)
- B. Employee handbook
- C. Procedure for handling employee complaints of discrimination or sexual harassment

NOTICE TO APPLICANT ³/₄ PLEASE READ CAREFULLY.

FOR THE PURPOSES OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE UNDERWRITER IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE UNDERWRITER TO COMPLETE, OR THE APPLICANT TO PURCHASE, THE INSURANCE.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE UNDERWRITER AND ALONG WITH THE APPLICATION IS CONSIDERED PHYSICALLY ATTACHED TO THE POLICY AND WILL BECOME A PART OF IT. THE UNDERWRITER WILL HAVE RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING ANY POLICY. THE APPLICATION WILL BECOME A PART OF SUCH POLICY IF ISSUED.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE UNDERWRITER, WHO MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION.

THE UNDERSIGNED DECLARES THAT THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE UNDERSTAND THAT

- (I) THE POLICY SHALL APPLY ONLY TO "CLAIMS" MADE (OR DEEMED MADE) TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR TO "CLAIMS" MADE TO THE UNDERWRITER DURING ANY APPLICABLE "EXTENDED REPORTING PERIOD";
- (II) THE LIMIT OF LIABILITY CONTAINED IN THE POLICY SHALL BE REDUCED, AND MAY BE COMPLETELY EXHAUSTED, BY "DEFENSE EXPENSES" AND, IN SUCH EVENT, THE UNDERWRITER SHALL NOT BE LIABLE FOR "DEFENSE EXPENSES" OR FOR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT TO THE EXTENT THAT SUCH COST OR LIMIT EXCEEDS THE LIMIT OF LIABILITY IN THE POLICY; AND
- (III) "DEFENSE EXPENSES" THAT ARE INCURRED SHALL BE APPLIED AGAINST THE RETENTION AMOUNT.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: 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 DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: 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 OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: 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 IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: 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 DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

APPLICANT:		
BY (<i>President, Chairman, or CEO</i>):	TITLE:	DATE:

NOTE: This Application must be signed by the President, Chairman, or CEO of the **Applicant** acting as the authorized agent of the person(s) and entity(ies) proposed for this insurance.

REQUIRED INFORMATION

PRODUCED BY (*Insurance Agent or Broker*):
Please print and sign name

FIRM NAME:

TAXPAYER ID OR SOCIAL SECURITY NO.:

PRODUCER LICENSE NO.:

ADDRESS (*No., Street, City, State, and ZIP*):

EMAIL ADDRESS:

SUBMITTED BY (*Firm*):

TAXPAYER ID OR SOCIAL SECURITY NO.:

PRODUCER LICENSE NO.:

ADDRESS (*No., Street, City, State, and ZIP*):

**EXECUTIVE RISK INDEMNITY INC.
APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE FOR ACCOUNTING FIRMS
FIRM FINANCIAL INFORMATION SUPPLEMENT**

Name of **Applicant**: _____

This supplement is part of the Application for Employment Practices Liability Insurance for Accounting Firms.

Please supply the following information and the source financial documents listed below. For items 1, 2, and 3, supply information for your latest completed fiscal year and the prior two fiscal years. For items 4, 5, and 6, please supply the amount at year end.

- | | Latest Fiscal Year
(ending __/__/__) | 1st Prior Fiscal Year
(ending __/__/__) | 2nd Prior Fiscal Year
(ending __/__/__) |
|--|---|--|--|
|--|---|--|--|
-
- 1. Gross Revenues:**
Cash receipts from professional services, excluding expense reimbursements.

 - 2. Net Income:**
Total net income for distribution to active equity partners or shareholders.

 - 3. Total Debt (Net present value):**
The sum of long- and short-term debt to all creditors. Please indicate the discount rate used to compute net present value. (If net present value estimate is not available, list each obligation and its maturity date.)

 - 4. Lease Obligations (Net present value):**
Please include all leases — e.g., for real estate, furnishings, office equipment, etc. Please indicate the discount rate used to compute net present value. (If net present value estimate is not available, list all leases and show payment due by year for each.)

 - 5. Obligations to Former Partners/Shareholders (Net present value):**
Total of all payments due to retired partners/shareholders or former partners/shareholders, for whatever reasons. Please indicate the discount rate used to compute net present value. (If net present value estimate is not available, please list obligations per year for each individual.)

 - 6. Partner or Shareholder Equity:**
Total partner or shareholder equity.

Please provide latest fiscal year financial statements (income statement and balance sheet), audited if available, with this supplement.

I understand that information submitted herein becomes part of the Applicant's Application for Employment Practices Liability Insurance for Accounting Firms and is subject to all of the representations and conditions set forth therein.

Authorized Signature of **Applicant** (Principal, Partner, or Shareholder)

Date

Print Name