Liberty Mutual INSURANCE

EMPLOYEE PRACTICES LIABILITY APPLICATION

THIS IS AN APPLICATION FOR CLAIMS MADE COVERAGE, DEFENSE COSTS ARE SUBJECT TO THEIR OWN LIMIT OF INSURANCE AND ARE SUBJECT TO THE DEDUCTIBLE. PLEASE READ THE COVERAGE FORM CAREFULLY.

A. APPLICANT INFORMATION

1. Legal Name of Entity: _____ Agent: _____
   Mailing Address: _____

2. Supporting Policies: _____

3. Proposed Policy Period: From: _____ To: _____ Proposed Retroactive Date: _____

4. Does the applicant have any contracts with or receive financial assistance from the Federal Government?
   ❑ Yes ❑ No
   If "yes", please describe contracts including revenue size and any financial assistance (if additional space is needed, use Section G. of this application): _____

   Is there an affirmative action plan? ❑ Yes ❑ No If "yes", please attach copy and describe reason for implementing: _____

B. LIMITS AND COVERAGE INFORMATION

1. Limits (Each Claim/Aggregate - Damages and Each Claim/Aggregate - Defense Expense):
   ❑ $50,000/$50,000 ❑ $150,000/$150,000 ❑ $250,000/$250,000 ❑ $500,000/$500,000
   $50,000/$50,000 $150,000/$150,000 $250,000/$250,000 $500,000/$500,000
2. Deductible Amount: ❑ $2,500 ❑ $5,500 ❑ $10,000 ❑ $25,000
3. Coinsurance Participation: ❑ 0% ❑ 5% ❑ 10% ❑ $25,000 cap ❑ $50,000 cap
4. Coverage for Injury to Independent Contractors? ❑ Yes ❑ No
   If "yes", provide details of contracts including number of workers, type of work, average hours/week and/or month of use, and whether workers are primarily on site or off site (if additional space is needed, use Section G. of this application): _____

C. EMPLOYEE DATA

1. Please indicate total number of locations and employees by state, and totals for each year as follows:

	State	#of Locations	# of Full Time Employees	#of Part Time Employees*	#of Temporary/ Leased Employees	#of Independent Contractors**
Current Year:						
Current Year Totals:						
1st Prior Year:						
1st Prior Year Totals:						
2nd prior Year:						

2nd Prior Year Totals: _____ _____ _____ _____ _____

* Defined as employees working less than 32 hour per week/1600 hours per year

** Injury to Independent Contractors is not covered under the basic coverage form, but their use must be reported. If coverage is desired, please complete item B.4. above.

2. Indicate percent of workforce that are union members:
   Current Year: _____ 1st Prior Year: _____ 2nd Prior Year: _____

3. Provide breakdown of current Full Time employees by their total cash compensation (salary and bonus) as follows:

Salary Ranges	#of Employees	% of total
$30,000 of less per year	_____	_____
$30,001-$100,000 per year	_____	_____
Over $100,000 per year	_____	_____

4. Indicate number of Full Time and Part Time employees terminating employment during the year divided by the total at the start of the year (turnover ratio):
   Current Year: _____ % 1st Prior Year: _____ % 2nd Prior Year: _____ %

5. Indicate number of employer initiated terminations of Full Time and Part Time employees:
   Current Year: _____ 1st Prior Year: _____ 2nd Prior Year: _____

D. POLICIES AND PROCEDURES INFORMATION

1. Do you have a specific department that is dedicated to the human resource or personnel function?
   ❑ Yes ❑ No
   If "no", who is responsible for the human resource or personnel function?
   Name: _____ Title: _____

2. a. Have all your employment related policies and procedures been reviewed and approved by outside counsel? ❑ Yes ❑ No
      If "yes", when? _____ By whom? Firm: _____ Attorney: _____
   b. Have all recommendations from that review been implemented? ❑ Yes ❑ No
      If "no", please explain recommendations that have not been implemented, and reason why or timeframe for compliance (if additional space is needed, use Section G. of this application): _____

3. Do you use a written employment application for all your applicants for hire?
   ❑ Yes ❑ No

If yes, does it contain:	Yes	No
a. An employment at will statement?	❑	❑
b. Authorization to check references and criminal conviction records?	❑	❑
c. The applicant's signautre attesting that all representations are true?	❑	❑
d. An equal employment opportunity statement?	❑	❑

4. Do you distribute an employment handbook to each employee?
   ❑ Yes ❑ No

If yes, does it contain:	Yes	No
a. An employment at will statement?	❑	❑
b. A written equal employment opportunity statement?	❑	❑
c. A written anti-sexual and general harassment policy?	❑	❑
d. A written internal complaint procedure for discrimination and harassment claims?	❑	❑
If "no", do you separately distribute written policies on all the above?	❑	❑

5. Are written policies and procedures in place for the following:

	Yes	No
a. At least annual written performance evaluations for all employees?	❑	❑
b. Grievance program?	❑	❑
c. Progressive disciplinary program?	❑	❑
d. Family and Medical Leave?	❑	❑
e. Job titles and descriptions?	❑	❑

   If "yes" to any of the above:
   i. Are these policies and procedures accessible to all managers and supervisors?
      ❑ Yes ❑ No
   ii. Do your managerial and supervisory employees receive regular training in the implementation of these programs and procedures?
      ❑ Yes ❑ No

iii. With regard to item d. avove, is information distributed as required by the Family and Medical Leave Act?

6. Are all federal, state and municipal mandated notices posted in locations conspicuous to all employees and applicants for employment?
❑ Yes ❑ No

7. Is counsel sought from a Human Resource employee or an attorney before an employee is terminated?
❑ Yes ❑ No

8. Do you make use of any of the following tests to screen employment applicants, to promote employees, or for the purpose of continuing employment?
a. Psychological or personality tests ❑ Yes ❑ No
b. Drug or alcohol tests ❑ Yes ❑ No
c. Pre employment offer medical test ❑ Yes ❑ No
If "yes", please describe type of test, how it is administered, company creating test and validation documentation (if additional space is needed, use Section G. of this application: _____

9. Do you have written procedures that facilitate prompt recording and reporting of claims, and incidents that can reasonably be expected to result in claims?
❑ Yes ❑ No
If "yes", enclose a copy. Are these procedures communicated to all your management and supervisory employees?
❑ Yes ❑ No

List the name of the individual you have designated to handle the reporting of claims, lawsuits and incidents that may reasonably be expected to result in a claim.

Name Title Phone #

10. Please attach a copy of each of the following, if it exists:
Employee handbook
Employee grievance, disciplinary, termination and out-placement procedures
Employment application form(s)
Equal Emmployment Opportunity and Discrimination and Harassment policies
Separation Agreement Form

E. PREVIOUS INCIDENT AND LOSS INFORMATION

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

1. Are you aware of any employment related facts, incidents or circumstances involving, or complaints or charges against you or any of your current or former employees that have not yet resulted in claims for damages but can reasonably be expected to do so?
❑ Yes ❑ No If "yes", please provide details (if additional space is needed, use Section G. of this application):

Date of Incident	Currrent Status	Description of Incident

2. List all employment related claims, administrative proceedings, lawsuits and settlements within the past 5 years against you or any of your current or former employees (if additional space is needed, use Section G. of this application):

Date of of Loss	Amount of Incurred Loss	Current Status	Description of Loss	Valuation Date	Source of Data

3. Have you received any employment related inquiry, complaint or charge from any municipal, state or federal regulatory authority

or any other governmental entity?

❑ Yes ❑ No If "yes", please provide details (if additional space is needed, use Section G. of this application):

4. a. Have you had any plant, facility, branch or office closings, consolidations, layoffs or staff reductions (greater than 10% of your workforce), mergers or acquisitions in the past 2 years?

❑ Yes ❑ No

b. Do you anticipate any of the above within the next 12 months?

❑ Yes ❑ No

If "yes" to any of the above, please provide details (if additional space is needed, use Section G. of this application):

F. PREVIOUS INSURANCE INFORMATION

1. Has any similar policy or application for employment related practices liability insurance been declined, cnacelled or renewal refused within the last five years?

❑ Yes ❑ No If "yes", please provide details (if additional space is needed, use Section G. of this application):

2. List your previous carrier(s) for similar employment related practices liability insurance:

Company Name	Policy Period	Retro Date	Limits	Coinsurance Deductible	Premium

G. ADDITIONAL COMMENTS

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 SUPPLEMENT 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 RESULT, THE INSURED MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.

THE APPLICANT 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 AND POLICY.

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

INSURANCE FRUAD WARNING

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 sujects the person to criminal and civil penalties. In ME and VA, insurance benefits may also be denied. (Not applicable in OH)

Signature of President or Chairman **Date**

Signature of Individual responsible for Human Resource function **Date**