

Employment Practices Liability Insurance – APPLICATION for CAP PROGRAM

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED INSURANCE POLICY

1. Name of Applicant _____
Address _____

- Phone: (____) _____ Fax: (____) _____
2. Organization's Legal Structure: Corporation Partnership Other _____
3. Desired Coverage Limit \$ _____ Number of Locations? _____
4. Number of Employees: Full Time _____ Part Time _____ Temporary _____ Seasonal _____
Independent Contractors _____
(Please count each independent contractor that you want to be included for coverage as 1 regular full time employee. Part time employees work fewer than 25 hours. Full time employees work greater than 25 hours).
5. Has the Organization reduced staff (voluntary or involuntary) by more than 25% (excluding seasonal employees) in any of the last three (3) years? Yes No
(If Yes, under the terms of this program, you do not qualify).
6. Does the Organization anticipate closing any facilities, reducing any staff or laying off any employees (excluding seasonal employees) during the next 24 months? Yes No
(If Yes, please state the reason for the action and identify the number of employees affected. Coverage will be considered, but cannot be bound until approved by Underwriters).
7. Does your employee handbook contain the following policies: Sexual Harassment, Equal Employment Opportunity (EEO) and "At Will" employment? Yes No
(If No, coverage cannot be provided until these policies are in place.)
8. Does the organization utilize an employment application that contains a statement advising the employee that the employment relationship between the organization and the employee is an "At Will" relationship? Yes No
(Coverage cannot be provided unless you use an application that contains an "At Will" disclosure).
9. Within the last 5 years, has the Organization had any employment related claims/incidences (excluding workers compensation) or been named as a defendant or respondent in any regulatory actions involving a federal, state or local agency? Yes No
(If Yes, under the terms of this program, you do not qualify).
10. Is any director, officer, owner, member, partner or supervisory employee of the Organization aware of any fact, circumstance or situation which would indicate the probability of a claim for a wrongful employment practice that may be brought against any proposed Insured? Yes No
(If Yes, under the terms of this program, you do not qualify).

Notice to the Insured

- A. The applicant represents to the best of its knowledge and belief that the statements set forth herein are true and complete.
- B. The applicant agrees that after receipt of the completed application form, NAS has 5 working days from the date the application is received to either confirm or deny coverage. It is agreed that this application shall be the basis of the insurance and will be attached to and made part of the policy should a policy be issued.
- C. The applicant further represents that if the information supplied on this application changes between the date of the Application and the inception date of the policy period, the applicant will immediately notify the underwriter of such change, and the underwriter may modify or deny coverage.

Signed: _____ Date: _____
Authorized Signature (Principal or Officer)

PLEASE COMPLETE AND FAX TO (213) 473-8771