

CAP PHYSICIANS INSURANCE AGENCY

EPLI writeNOW! APPLICATION

THIS IS A PROPOSAL FORM FOR A POLICY RELATING TO CLAIMS MADE AGAINST THE INSURED DURING THE TERM OF THE POLICY

Section One - Applicant

1) Name of Organization _____

Address _____

(City)

(State)

(Zip Code)

2) NAS HResource™ Contacts (please provide 2 contacts):

(Name) (Title) (Phone) (Fax) (Email)

(Name) (Title) (Phone) (Fax) (Email)

3) Organization's Legal Structure: Corporation: _____ Partnership: _____ LLC: _____

Other (Describe): _____

4) Subsidiaries to be included? (If "Yes", please attach a schedule) Yes No

5) Nature of operations: _____

6) Date operations commenced under current ownership: _____

7) Number of Employees (including all physicians, allied health, office staff, temporary employees, etc. and independent contractors):

Full Time: _____ Part Time: _____ Temporary/Seasonal: _____

Independent contractors working exclusively for the Applicant: _____

(Full time employees count as 1 employee. Part time employees count as 1/2 an employee. Seasonal and temporary employees count as 1/3 an employee. Independent contractors count as 2/3 an employee.)

8) Does the organization currently utilize an employee handbook? Yes No

9) Is the Applicant compliant with all mandatory postings as required by law? Yes No
(If "No", coverage cannot be bound until postings are in place)

10) Does the organization have an Employment Practices Liability Policy coverage in force? Yes No
If "Yes", please indicate:

The Insurer: _____ Expiration Date: _____

Limit: _____ Deductible: _____ Premium: _____

For questions 11 through 19, if the answer is "Yes", coverage cannot be bound per the terms and conditions of this program. If you desire an indication outside the program, please provide details for the "Yes" answers.

- 11) Has the Organization reduced staff (voluntary or involuntary) by more than 25% (excluding seasonal employees) in the last 12 months? Yes No
- 12) Does the organization anticipate closing any facilities, reducing any staff, or laying off any employees (excluding seasonal employees) during the next 12 months? Yes No
- 13) Has the Organization terminated any senior manager, officer or partner within the last 18 months? Yes No
- 14) Within the last five years, has any person or entity proposed for this insurance had any employment or third party related claims/incidents or been named as a defendant or respondent in any regulatory actions including Wage and Hour violations involving a Federal, State or local EEO agency? Yes No
- 15) Is any person or entity proposed for this insurance aware of any wrongful acts, facts, incidents, situations or any circumstances which would indicate the probability of a claim for wrongful employment practice or wrongful third party claims, including Wage and Hour violations that may be brought against any proposed insured? Yes No

WAGE AND HOUR SUPPLEMENTAL QUESTIONS (#16 & #17):

- 16) Within the last three (3) years, has the Applicant had any claim for any violation of wage and hour laws including, but not limited to, claims related to meal periods, rest periods or unpaid overtime? Yes No
- 17) Does any manager, supervisor, shareholder, partner or owner proposed for this insurance, have knowledge of a potential violation of any wage and hour law that could result in a claim for any violation of wage and hour laws including, but not limited to, claims related to meal periods, rest periods or unpaid overtime? Yes No

DIRECTORS AND OFFICERS QUESTIONS (#18 & #19):

- 18) Within the last five years, has any person or entity proposed for Directors and Officers Liability Insurance been subject of or been involved in any litigation, administrative proceeding, demand letter, formal or informal governmental investigation or inquiry of a type which might be covered by Directors & Officers Liability Insurance? Yes No
- 19) Is any person or entity proposed for this insurance aware of any wrongful acts, facts, incidents, situations or any circumstances which would indicate the probability of a Directors and Officers claim or wrongful act? Yes No

Section Two – Coverage Selection and Premium Calculation
(Check options desired):

EPLI COVERAGE: EPLI Broad

EPLI LIMIT: \$250,000 \$500,000 \$1,000,000

EPLI SIR: \$50,000 Costs, Charges and Expenses per Claim, subject to a minimum SIR of \$5,000 SIR per Claims

D&O COVERAGE: D&O

D&O LIMIT : Same as EPLI Limit above

D&O SIR: \$0/\$5,000/\$5,000

Requested effective date (no backdating): _____

A 3.25% CA tax & fee will apply

Section Three – Notice to the Applicant

- 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, underwriters have five working days to either confirm or deny coverage. It is also agreed that this application shall be the basis of 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 of a Principal or Officer
(Must be signed and dated no more than 45 days prior to binding)

NOTICE:

- 1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED "NONADMITTED" OR "SURPLUS LINE" INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
- 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
- 4. THE INSURER SHOULD BE LICENSED EITHER AS A FOREIGN INSURER IN ANOTHER STATE IN THE UNITED STATES OR AS A NON-UNITED STATES (ALIEN) INSURER. YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR "SURPLUS LINE" BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357. ASK WHETHER OR NOT THE INSURER IS LICENSED AS A FOREIGN OR NON-UNITED STATES (ALIEN) INSURER AND FOR ADDITIONAL INFORMATION ABOUT THE INSURER. YOU MAY ALSO CONTACT THE NAIC'S INTERNET WEB SITE AT WWW.NAIC.ORG.**
- 5. FOREIGN INSURERS SHOULD BE LICENSED BY A STATE IN THE UNITED STATES AND YOU MAY CONTACT THAT STATE'S DEPARTMENT OF INSURANCE TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.**
- 6. FOR NON-UNITED STATES (ALIEN) INSURERS, THE INSURER SHOULD BE LICENSED BY A COUNTRY OUTSIDE OF THE UNITED STATES AND SHOULD BE ON THE NAIC'S INTERNATIONAL INSURERS DEPARTMENT (IID) LISTING OF APPROVED NONADMITTED NON-UNITED STATES INSURERS. ASK YOUR AGENT, BROKER, OR "SURPLUS LINE" BROKER TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.**
- 7. CALIFORNIA MAINTAINS A LIST OF APPROVED SURPLUS LINE INSURERS. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: WWW.INSURANCE.CA.GOV.**
- 8. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

Date: _____

Insured: _____