

Employment Practices Liability Insurance

CLAIMS MADE WARNING FOR APPLICATION

THIS PROPOSAL FORM IS FOR A CLAIMS MADE POLICY, RELATING TO CLAIMS MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the Policy. This Proposal Form is to be completed with respect to the entire Insured Entity. Insured Entity as used herein is defined to include the Named Insured and any Subsidiaries. Provide details to all "Yes" answers, when applicable, by attachment.

Name of Named Insured

Street Address

City

State

Zip Code

The Officer designated as agent of the Insured Entity and of all Insureds to receive any and all notices from the Insurer or their authorized representatives concerning this insurance:

Name

Title

E-Mail Address

General Information

- 1. (a) Primary Standard Industry Code (SIC):
(b) Federal Employer Identification Number (FEIN) or Taxpayer Identification Number:
(c) Describe the nature of the Named Insured's business:

- 2. Is the Insured Entity a federal government contractor and/or subject to Executive Order No. 11246?
3. Has the Insured Entity been involved in any bankruptcy proceeding within the last 12 months or has the Insured Entity contemplated filing a petition for protection under the bankruptcy code within the next 12 months?
4. Provide the following information on all Subsidiaries of the Insured Entity. If "None", so state.
5. Provide the following information on all new, within the last 12 months, plants, branches or offices of the Insured Entity. If "None", so state.

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES IN QUESTION 4. UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED BY ATTACHMENT. ALSO, PROVIDE DETAILS TO QUESTION 5. BY ATTACHMENT, AS APPROPRIATE.

- 6. Has the Insured Entity had any Subsidiary, plant, facility, branch or office closings, consolidations or layoffs within the past 12 months, or anticipate any within the next 24 months?
7. Has the Insured Entity conducted any analysis or studies of any particular Subsidiary, plant, facility, branch or office which may relate to future restructuring of the Insured Entity or its workforce?

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Current Employee Information

8. Have there been any changes in senior management in the last 12 months? Yes No
9. (a) Number of **Employees**:
- | | Total Number | | Voluntary Terminations | | Involuntary Terminations | |
|--------------|--------------|-----------|------------------------|-----------|--------------------------|-----------|
| | Full Time | Part Time | Full Time | Part Time | Full Time | Part Time |
| Current Year | | | | | | |
| Prior Year | | | | | | |
- (b) Does the **Named Insured** employ, during the course of the year, more than 10 percent of its total workforce in seasonal laborers, or utilize temporary **Employees**? Yes No
10. Annual pay ranges:
- | | Number of Full Time Employees | Number of Part Time Employees |
|-----------------------|--------------------------------------|--------------------------------------|
| \$50,000 or less | | |
| \$50,001 to \$100,000 | | |
| \$100,001 and over | | |
11. (a) Does the **Insured Entity** currently employ a full time Human Resources professional? Provide details below, as appropriate. Yes No
 If "Yes", what is the name and title of the senior Human Resources professional?
 Name: _____ Title: _____
 If "No", what is the name and title of the person who performs the Human Resource function?
 Name: _____ Title: _____
- (b) Does the **Insured Entity** currently utilize employment counsel? Provide details below, as appropriate. Yes No
 If "Yes", what is the name of the firm utilized? Firm: _____
12. Does the **Insured Entity** (details to "Yes" or "No" answers are not required by attachment):
- (a) Utilize employment applications for all prospective **Employees**? Yes No
- (b) Conduct reference checks on all prospective **Employees**? Yes No
- (c) Use any tests, including drug or skill tests to screen applicants, or to promote or monitor **Employees**? Yes No
- (d) Maintain a personnel file on each **Employee**? Yes No
- (e) Maintain confidential and segregated **Employee** medical records? Yes No
- (f) Have a document retention policy for all **Employee**/employment related documents? Yes No
 If "Yes", how long are they retained? _____
- (g) Inform all **Employees** in writing that their employment relationship is "at-will"? Yes No
- (h) Require the Human Resource Department to review and approve each proposed **Employee** termination? Yes No
- (i) Have outside employment counsel review each proposed **Employee** termination? Yes No
- (j) Document each **Employee's** personnel file with all reasons for termination? Yes No
- (k) Require any **Employee(s)** to retire upon attaining a certain age? Yes No
- (l) Have written employment agreements with any **Employees**? Yes No
- (m) Have collective bargaining agreements with any group of **Employees**? Yes No
- (n) Maintain a written arbitration policy/procedure for employment related disputes? Yes No
- (o) Maintain a written policy prohibiting Sexual Harassment and distribute that policy to all **Employees**? Yes No
- (p) Have a policy prohibiting the display or distribution of material, whether printed or electronic, which may be deemed offensive to others, and distribute that policy to all **Employees**? Yes No
- (q) Conduct mandatory periodic **Employee** education regarding prohibited forms of harassment? Yes No
- (r) Periodically have its employment policies and procedures reviewed by outside employment counsel? Yes No
13. Indicate which formal written policies and procedures have been implemented and attach a copy of each. If "None", so state. None
- | | | |
|--|---|--|
| <input type="checkbox"/> Written Employee Evaluation Policy | <input type="checkbox"/> Anti-Harassment Policy, including Sexual Harassment | <input type="checkbox"/> Anti-Discrimination Policy |
| <input type="checkbox"/> Progressive Discipline Policy | <input type="checkbox"/> Adherence to Employment "at-will" relationship with all Employees | <input type="checkbox"/> Complaint / Grievance Procedure |
| <input type="checkbox"/> Human Resources Manual (or equivalent guidelines) | | <input type="checkbox"/> Workplace Safety Policy |
| | | <input type="checkbox"/> Family Medical Leave Act Policy |

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Litigation and Claim Information

14. In the last 5 years, has any current or former **Employee** or third party made any **Claim**, or otherwise alleged discrimination, harassment, wrongful discharge and/or **Wrongful Employment Act(s)** against the **Insured Entity** or its directors, officers or **Employees**? Yes No

A **Claim** is not limited to the filing of a lawsuit or complaint with the EEOC or similar state or local agency. A **Claim** may also include a written demand or threat by any current or former **Employee** seeking relief in connection with an employment-related dispute or grievance. Please provide details of all incidents even if the matter has since been settled or otherwise resolved.

15. During the last 5 years, has the **Insured Entity** or any of its directors, officers or **Employees** thereof known of, or been involved in any lawsuit, charges, inquiries, investigations, grievances or other administrative hearings or proceedings before any of the following agencies and/or under any of the following forums?
- (a) National Labor Relations Board? Yes No
 - (b) Equal Employment Opportunity Commission? Yes No
 - (c) Office of Federal Contract Compliance Programs? Yes No
 - (d) U.S. Department of Labor? Yes No
 - (e) Any state or local government agency such as the Labor Department or fair employment agency? Yes No
 - (f) U.S. District or state court? Yes No

Provide details of all incidents even if the matter has since been settled or otherwise resolved.

IF "YES" TO QUESTION 14. OR ANY PART OF QUESTION 15., PROVIDE THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT, OR BY COMPLETING A CLAIMS SUPPLEMENT FORM.

- | | | | | |
|----------------|-------------------------------------|--|---|--------------------------|
| (a) Allegation | (b) Date Claim
first made | (c) Paid damages/expenses
including attorneys' fees | (d) Outstanding damages/expenses
including attorneys' fees | (e) Total costs incurred |
|----------------|-------------------------------------|--|---|--------------------------|

Documents Required

Please submit one copy of each of the following documents. These documents will be attached to and made a part of this Proposal Form.

- (a) Provide details to all "Yes" answers, when applicable, by attachment
- (b) The most recent (if implemented in the last 12 months) or all updates made to the existing Employee Handbook or Employee Policy Manual

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Please Read Carefully

The undersigned Chairman of the Board of Directors, President or Chief Executive Officer and Human Resources Manager declare that to the best of their knowledge the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Proposal Form.

The undersigned agree that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and that they are material and are the basis of the insurance contract. The undersigned further agree that the Proposal Form and any material submitted herewith shall be considered attached to and a part of the Policy.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the Policy inception date, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any Policy, if issued, will be in reliance upon the truth of such representations; provided, however, with respect to such statements and representations, no knowledge or information possessed by any **Director or Officer or Employee**, except for those person or persons who executed the Proposal Form, shall be imputed to any other **Director or Officer or Employee** and further provided that if any person who executed the Proposal Form knew that such statement or representation was inaccurate or incomplete, then this Policy will be void as to all **Insureds**;
- the information contained in this Proposal Form shall not be used by any **Insureds** as notice as provided for in section VII. of the Policy, nor will the **Insurer** recognize and/or accept the information contained herein as notice as provided for in section VII. of the Policy;
- this Proposal Form has been completed as respects the entire Insured Entity;
- the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

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 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 NEW MEXICO, 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.

NOTICE TO APPLICANTS OF KENTUCKY: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A CRIME AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO APPLICANTS OF FLORIDA, MINNESOTA, NEW JERSEY, OHIO, AND OKLAHOMA: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, MASSACHUSETTS 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

	Dated:
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Chairman of the Board of Directors, President or Chief Executive Officer

	Dated:
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Human Resources Manager (or equivalent position)

This Admiral Insurance Company Proposal Form, including any material submitted herewith, shall be held in strictest confidence.

A POLICY CANNOT BE ISSUED UNLESS THE PROPOSAL FORM IS PROPERLY SIGNED AND DATED.

Please submit this Proposal Form including appropriate documentation to:

Monitor Liability Managers, Inc., 2850 West Golf Road, Suite 800, Rolling Meadows, IL 60008-4034

	Dated:
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Submitted by (PRODUCER)

Admiral Insurance Company

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AGENT'S NAME (Please Print Name Here)

AGENT'S LICENSE NUMBER