

SCOTTSDALE INSURANCE COMPANY®

Home Office:
One Nationwide Plaza • Columbus, Ohio 43215
Administrative Office:
8877 North Gainey Center Drive • Scottsdale, Arizona 85258
1-800-423-7675 • Fax (480) 483-6752

Employment Practices Liability Insurance

This application is for a Claims Made policy.

All questions must be answered. If a question does not apply, indicate "N/A."

GENERAL INFORMATION

1. Name: _____
2. Address: _____
City: _____ State: _____ Zip Code: _____
Additional Locations: _____
3. Business Type: Corporation Partnership Professional Corporation
 Individual Other (specify): _____
4. Date Business Established: _____
5. Describe Nature of Business: _____

6. Complete the following for any subsidiaries you want covered. Include these employees in Question #10:

Name	Location	Nature of Business	% of Interest	Date Acquired	# of Employees

7. With respect to mergers and acquisitions, have you:

- a. Merged or acquired another entity in the last 24 months? Yes No
- b. Any plans to merge or acquire another entity within next 24 months? Yes No

If yes to either question a. or b., complete the following:

Name	Location	Nature of Business	% of Interest	Date Acquired

8. With respect to acquired companies, did YOU terminate any employees or officers? Yes No

If yes, how many employees? _____ officers? _____

Do you plan to terminate any employees or officers within the next 18 months? Yes No

If yes, how many employees? _____ officers? _____

9. Any plans to close an office or lay off 5% or more of employees within the next 24 months? Yes No

If yes, please explain: _____

Do you have a formal "reduction in force" policy? Yes No If yes, provide copy.

If no, how will the closings be handled? _____

EMPLOYEE INFORMATION

10. By state, please list the total number of locations and employees including subsidiaries for which you want coverage, broken down by Full Time employees (FT), Part Time employees* (PT), Temporary employees (T) and Leased employees** (L):

Current Year: _____					Prior Year: _____					Third Year: _____							
State	Number of Locations by State	Employees				State	Number of Locations by State	Employees				State	Number of Locations by State	Employees			
		FT	PT	T	L			FT	PT	T	L			FT	PT	T	
Totals						Totals						Totals					

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

**All Leased employees are to be shown under "(L)" category, whether Part Time or Temporary.

Current number of Independent Contractors: _____

Please note that no coverage is afforded for Independent Contractors unless specifically requested and endorsed to the policy. Do you want coverage for Independent Contractors? Yes No (if yes, additional information will be required.)

11. Current number of employees that are union versus non-union: Union: _____ Non-union: _____

12. Breakdown of current Full Time employees by their total cash compensation (salary + bonus):

Salary Ranges	# of Employees	% of Total
\$30,000 or less per year		
\$30,001-\$100,000		
Over \$100,000 per year		

13. How many employees have been terminated in the past 3 years:

	Current Year: _____		Prior Year: _____		Third Year: _____	
	Voluntary	Involuntary	Voluntary	Involuntary	Voluntary	Involuntary
Employees						
Officers						

EMPLOYMENT INFORMATION

- 14. Do you have a Personnel/Human Resource Department?** Yes No
- a. If yes, number of staff: _____ To whom does Personnel/HR report? _____
Highest level of training of any one staff member: _____
- b. If no, explain who is responsible for this function, the person's qualifications and how long in position: _____
- c. Do all managers and supervisory personnel receive training on how to conduct proper:
- | | | | |
|-------------------------|--|------------------|--|
| Interviews? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Terminations? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Performance Reviews? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Exit interviews? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Progressive Discipline? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
- d. Do all managers and supervisory personnel receive training on the company's policies and procedures for:
- | | | | |
|-----------------|--|----------------------|--|
| Discrimination? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexual Harassment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Termination? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Handling Complaints? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- e. Does the company provide any additional training for employees on preventing DISCRIMINATION and HARASSMENT? Yes No
- If yes, how is this done? _____

- 15. Do you have an employee handbook or manual?** Yes No If yes, please provide a copy.
- a. Does every employee receive a copy? Yes No
- b. Does the handbook contain:
- | | |
|---|--|
| (1) Sexual Harassment policy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (2) Equal Opportunity Employer statement? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (3) Employment-at-Will Statement? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- Are these policies distributed annually to all employees? Yes No
- Do you obtain signed acknowledgment of receipt of the information distributed annually from each employee?
 Yes No
- c. Do you get written acknowledgment that employee received handbook? Yes No
- d. How often is the manual reviewed? _____
- e. Has it been reviewed by a labor relations attorney? Yes No
- f. What is the date of the last update? _____
- If no handbook, how does the company relay its employment policies and procedures to employees? _____

Please attach copy of these policies and procedures.

- 16. Do you have a formal, standardized employment application?** Yes No If yes, please provide a copy.
- | | |
|--|--|
| a. Has it been reviewed by a labor relations attorney? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Does it have an Employment-at-Will statement? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Does it have an Equal Opportunity Employer statement? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- If no application is used, how do you recruit new employees? _____

17. Do you use any psychological tests to screen applicants, to promote employees or for the purposes of continuing employment? Yes No If yes, describe type of test and how the test is administered, i.e., to all employees or segments: _____

Has the test been validated? Yes No If yes, please provide documentation on the validation.

18. Do you require drug testing or physical exams of employees? Yes No If yes, under what circumstances? _____

If requiring a physical exam or a drug test, do you do so only after a conditional offer of employment is made?
 Yes No

19. Do you use any other tests to screen applicants? Yes No If yes, describe: _____

20. Are all equal opportunity notices posted in common areas? Yes No

21. Have you reviewed your employment policies, practices and procedures to determine if you are in compliance with the Americans With Disabilities Act? Yes No

a. Have you or do you plan to implement changes to comply with the Act? Yes No

Please explain: _____

b. Do you have written emergency and/or evacuation procedures, including addressing the needs of the disabled?
 Yes No

22. Do you have written job descriptions on all positions? Yes No

23. Do you provide a written performance evaluation for all employees? Yes No
If yes, how often? _____

24. Do you have a written progressive disciplinary program? Yes No If yes, please attach a copy.

25. Do you have an established internal dispute resolution program? Yes No
If yes, please attach a copy.

26. Do you maintain written records of all reviews and disciplinary actions? Yes No

27. Do you have a written procedure for handling complaints? Yes No If yes, please attach a copy.

28. Do you require counsel from a human resource person or qualified labor relations attorney prior to terminating an employee? Yes No

29. Do you conduct exit interviews? Yes No

30. Do you offer:

a. A severance package? Yes No

b. A formal out-placement program to assist terminated employees in searching for other jobs? Yes No

CLAIMS HISTORY

31. Have there been any employment practices claims made against you, the firm or anyone proposed for this insurance, in the last 5 years? Yes No

If yes, please complete the Claim/Circumstance/Administrative Hearings Supplement.

32. Are you or anyone proposed for this insurance aware of any circumstances which might give rise to a claim under this policy? Yes No

If yes, please complete the Claim/Circumstance/Administrative Hearings Supplement.

33. Are you or anyone proposed for this insurance aware of any charges, inquiries, investigations, grievances or other administrative hearings currently before any of the following agencies and/or under any of the following acts?

- National Labor Relations Board Yes No
- Equal Employment Opportunity Commission Yes No
- Federal Labor Standards Act Yes No
- Fair Labor Standards Enforcement Act Yes No
- Title VII of the Civil Rights Act of 1964 Yes No
- Civil Rights Act of 1991 Yes No
- Age Discrimination in Employment Act Yes No
- Americans With Disabilities Act Yes No
- U.S. Department of Labor Yes No
- Any state or local government agency such as the Labor Department or Fair Employment Agency Yes No

If yes to any, please complete the Claim/Circumstance/Administrative Hearings Supplement.

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

INSURANCE INFORMATION

34. Has the proposed coverage ever been purchased? Yes No

If yes, please provide:

Policy Period	Retro Date	Insurer	Limits	SIR/Deductible	Coinsurance	Premium

35. Limits of Liability requested:

- \$1,000,000/\$1,000,000
- \$500,000/\$500,000
- \$250,000/\$250,000
- Other: _____

36. Deductible requested:

- \$5,000
- \$10,000
- Other: _____

SUBMIT WITH THIS APPLICATION

Copies of:

- (A) Employee Handbook—Question 15
- (B) Employment Application—Question 16
- (C) Progressive Discipline Procedures—Question 24
- (D) Complaint procedures—Question 27
- (E) EEO-1 Report for last calendar year (if there are over 50 employees)

SIGNATURE SECTION AND OTHER INFORMATION

NOTE: Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

NEW YORK—WARNING: 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.

FRAUD WARNING: 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.

THE APPLICANT AND FIRM ACCEPT NOTICE THAT ANY POLICY WHICH MAY BE ISSUED WILL APPLY ON A "CLAIMS MADE AND REPORTED" BASIS.

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 SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER 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 FIRM 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 ANY POLICY.

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

_____ Signature and Title of Principal (must be owner, partner or officer)	_____ Date
_____ Signature of individual responsible for Human Resources	_____ Date
_____ Producer's Name	_____ Area Code Phone Number

PRODUCER:

Will you make the surplus line filing for this policy? Yes No

Your Surplus Lines Number: _____



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APPLICANT'S INSTRUCTIONS:

- 1. Complete one form for each claim, circumstance or administrative hearing.
2. If space is insufficient to answer any question, use the reverse side or attach a separate sheet. Answer all questions

(PLEASE TYPE OR PRINT)

1. Name(s) of individual(s) in the company named in the claim: _____

2. Name of Claimant: _____

3. To what insurance company did you report this claim or incident? _____

A. Date of alleged error: _____ B. Date reported: _____ C. Date first notice received: _____

4. Present status of claim (check one): [] in suit [] open circumstance [] closed

A. If closed:

Total damages paid including claim expense and deductible: \$ _____

Indicate whether: [] court judgment, or [] out of court settlement.

B. If in suit or open:

Amount asked in summons \$ _____

Claimant's settlement demand \$ _____

Defendant's offer for settlement \$ _____

Insurer's loss reserve* \$ _____

Deductible \$ _____

*Unknown is unacceptable. Please contact the insurance company or the defense attorney for a good faith estimate.

5. Description of claim (provide enough information to allow evaluation and attach a separate page if additional space is required). Alleged act, error or omission upon which claimant bases claim: _____

6. Have you changed policies or procedures as a result of this claim that will reduce the possibility of a similar occurrence? [] Yes [] No If yes, please describe: _____

We understand that the information submitted herein becomes a part of the professional liability application and is subject to the same representations and conditions.

PRINCIPAL'S SIGNATURE: _____ DATE: _____

(Must be signed by an Owner, Partner or Officer)