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# ESI-EPL

## EMPLOYMENT PRACTICES LIABILITY INSURANCE

*This is an application for a claims-made and reported policy.*

**\*\*PREMIUM FINANCING AVAILABLE\*\***

**GENERAL INFORMATION**

- Requested effective date of Policy: \_\_\_\_\_
- Limits requested: from \$250,000/\$250,000 aggregate to \$5,000,000/\$10,000,000 aggregate: \_\_\_\_\_  
 (Higher limits available upon request)

Deductible requested: \$ \_\_\_\_\_ (Minimum US 2,500)

**Additional Coverage  
Requests on Page 4**

- Name of Company: \_\_\_\_\_
- Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Internet E-Mail: \_\_\_\_\_
- Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_
- Sole Proprietor  Corporation  Partnership  Joint Venture  Individual  Franchise  Other: \_\_\_\_\_
- Describe Nature of Business: \_\_\_\_\_

8. Number of Locations: \_\_\_\_\_ Which states? \_\_\_\_\_ No. Outside U.S.? \_\_\_\_\_  
*Please attach Supplemental Questionnaire Additional Insured(s) / Location (s) if more than one Insured or location is requested.*

9. How long have you been in business? \_\_\_\_\_ How long under current management? \_\_\_\_\_  
*(Please provide full details of any changes in the management of the company in the last five years on a separate sheet.)*

	<u>Gross Sales or Receipts</u>	<u>For Year Ended: mm/dd/yy</u>
Past financial year:	\$ _____	_____
Present financial year:	\$ _____ Est.	_____
Next financial year:	\$ _____ Est.	_____

11. Total number of employees (including Partners, Directors and Officers of all locations): *How many indicated are:*

	Regular	Temp/Leased	Contract	Seasonal		Union	Non-Union
Full Time:	_____	_____	_____	_____		_____	_____
Part Time:	_____	_____	_____	_____		_____	_____

*(If seasonal or temporary employees are used, please advise details on separate sheet.)*

12. Do you have any employees located outside the US? \_\_\_\_\_  
 If so, what percent of the total workforce is outside the US and in what country(s)? \_\_\_\_\_

13. Salary ranges (including bonuses & commissions):

	No. of F/T	No. of P/T		No. of F/T	No. of P/T
\$20,000 or less	_____	_____	\$20,001 to \$50,000	_____	_____
\$50,001 to \$100,000	_____	_____	\$100,001 and over	_____	_____

14. How many employees, officers or partners have been terminated in the past year?

Terminated by employer: Employees \_\_\_\_\_ Officers \_\_\_\_\_ Partners \_\_\_\_\_  
 Resigned voluntarily: Employees \_\_\_\_\_ Officers \_\_\_\_\_ Partners \_\_\_\_\_

15. What has been your annual percentage turnover rate of employees for the past one (1) year?

$\frac{\text{No. of separations during the year}}{\text{Total no. of employees}} \times 100 = \%$

19 \_\_\_\_\_ % 19 \_\_\_\_\_ % 19 \_\_\_\_\_ % 19 \_\_\_\_\_ % 20 \_\_\_\_\_ %

SECTION A

**COMPANY HISTORY & NARRATIVES**

- Have you acquired or merged with any companies or practices in the past two (2) years?.....YES  NO   
Do you anticipate merging with or acquiring any companies over the next 12 months? .....YES  NO   
(If YES to either of these questions, you will be expected to complete and attach the Supplemental Questionnaire for Mergers & Acquisitions)
  - With respect to acquired companies (or practices), were any employees, officers or partners terminated or do you plan in the next eighteen (18) months to terminate any employees, officers or partners? (If YES, please provide details on a separate sheet) .....YES  NO
  - Do you anticipate any plant, facility, branch or office closings, consolidations or layoffs affecting 20% or more of the employees within the next 24 months? .....YES  NO   
(If YES, please provide details on a separate sheet)
  - Has the proposed coverage ever been purchased before, whether specifically or as a sub-section or addition to other coverage?.....YES  NO
- | Year  | Renewal Date | Carrier | Limit | Deductible | Premium |
|-------|--------------|---------|-------|------------|---------|
| _____ | _____        | _____   | _____ | _____      | _____   |
- Has any insurer ever canceled or non-renewed this type of coverage? .....YES  NO   
(If YES, please provide details on a separate sheet)
  - Do you currently have an Affirmative Action Program?.....YES  NO   
If YES, indicate if it is a result of:  government contracts  EEOC compliance  
 voluntary  union agreement  other: \_\_\_\_\_
  - Do you currently carry Workers Compensation Insurance? .....YES  NO   
Please indicate:  Standard W/C  Self-Insured  Jones Act  
 Longshore & Harbor Workers Act  Other \_\_\_\_\_

**LOSS HISTORY**

*For example, but not by way of limitation, we consider it reasonable for you to foresee that a claim and/or allegation may be brought against you if a current or former employee or an applicant for employment has expressed dissatisfaction with the employment relationship or the employment application process by:*

- Making a formal complaint to a supervisory employee of discrimination, harassment or unfair employment practices;
- Threatening to hire an attorney or submission of a demand letter;
- Asking for a severance package in excess of what is being offered;
- Complaining of discrimination, harassment, or unfair treatment and threatening to do something about it; or
- Frequent complaining of discrimination, harassment or unfair treatment.

**IF YOU ANSWER YES TO QUESTIONS #1, 2 OR 3, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET.**

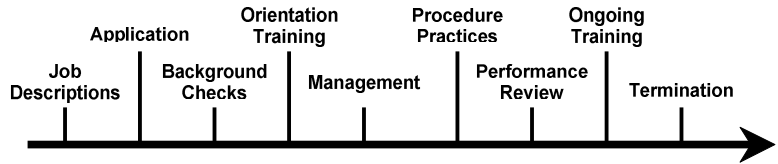
- Have you had any claims and/or allegations of inappropriate employment acts, discrimination, wrongful termination and/or sexual harassment (including both employee-related and third party actions) in the last 5 years?  
If YES, what was the total number of claims \_\_\_\_\_ & provide details .....YES  NO

***It is agreed that if there is knowledge of any such fact, circumstance, or situation, any claim subsequently emanating therefrom shall be excluded from coverage under the insurance being applied for.***

- Does any Director, Officer, Manager, Supervisory Employee or Partner have knowledge of any circumstances, as of the date this Application is signed, which could reasonably give rise to a claim and/or allegation or any reasonable way to foresee that one may be brought?.....YES  NO
- Please indicate below whether or not you have had any dealings or been involved with any of the following agencies and/or under any of the following Acts:

	YES	NO		YES	NO
Title VII Civil Rights Act of 1964/1991 (EEOC)	<input type="checkbox"/>	<input type="checkbox"/>	National Labor Relations Board	<input type="checkbox"/>	<input type="checkbox"/>
Harassment Claims (EEOC)	<input type="checkbox"/>	<input type="checkbox"/>	IRCA - Immigration Reform & Control Act	<input type="checkbox"/>	<input type="checkbox"/>
Americans with Disabilities Act	<input type="checkbox"/>	<input type="checkbox"/>	U.S. Department of Labor (including FMLA)	<input type="checkbox"/>	<input type="checkbox"/>
Age Discrimination in Employment Act	<input type="checkbox"/>	<input type="checkbox"/>	Fair Labor Standards Enforcement Act	<input type="checkbox"/>	<input type="checkbox"/>
Any state or local government agency such as the Labor Department or State Fair Employment Agency?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Any employment related retaliation or tort claim or hearing?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

# EMPLOYMENT LINE



## EMPLOYMENT PROCEDURES

SECTION D

1. Do you have a Human Resources or Personnel Department?.....YES  NO   
Please indicate number of persons in department. \_\_\_\_\_ If NO, who handles this function? \_\_\_\_\_
2. Do you have written employment contracts or employee agreements?  
(If YES, please supply samples and details).....YES  NO
3. Please indicate whether or not you use the following during pre-employment and/or orientation:
 

Job Descriptions.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Drug and Alcohol screens.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Reference Checks.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Employment Application.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Employment Tests.....YES <input type="checkbox"/> NO <input type="checkbox"/>	• At-Will Statement.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Medical Examinations.....YES <input type="checkbox"/> NO <input type="checkbox"/>	• Equal Opportunity Statement.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Orientation/Training program.....YES <input type="checkbox"/> NO <input type="checkbox"/>	
4. Please indicate whether or not you publish the following:
 

Employment handbook.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Grievance/open door procedures.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Drug and alcohol policy.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Health & safety complaint procedures.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Anti-sexual harassment policy.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Written arbitration procedures.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Anti-discrimination policy.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Required federal/state/local postings.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Family Medical Leave Act Policy.....YES <input type="checkbox"/> NO <input type="checkbox"/>	"Not an employment contract" language.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Equal Opportunity Statements.....YES <input type="checkbox"/> NO <input type="checkbox"/>	"At Will" language.....YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Please indicate whether or not you obtain employee signatures and/or acknowledgments on the following:  
(Individual policies or comprehensive handbook and a comprehensive acknowledgment will be acceptable)
 

Job Descriptions.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Employment Handbook.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Reference checks.....YES <input type="checkbox"/> NO <input type="checkbox"/>	• Effective date: MO/YR....._____/_____/_____
Employment Tests.....YES <input type="checkbox"/> NO <input type="checkbox"/>	• At-Will Statements.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Drug and Alcohol screening.....YES <input type="checkbox"/> NO <input type="checkbox"/>	• Equal Opportunity Statement.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Electronic Monitoring/E-Mail Policy.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Orientation/Training.....YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Please indicate whether or not you maintain and/or track the following:
 

Personnel records per employee.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Family Medical Leave Act (FMLA).....YES <input type="checkbox"/> NO <input type="checkbox"/>
Employee attendance.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Accurate payroll information.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Hours of sick leave accrual.....YES <input type="checkbox"/> NO <input type="checkbox"/>	Written performance evaluations.....YES <input type="checkbox"/> NO <input type="checkbox"/>
Hours of vacation pay accrual.....YES <input type="checkbox"/> NO <input type="checkbox"/>	
7. Do you post/publish required Dept. Of Labor FMLA notifications to employees using FMLA leave?.....YES  NO   
If NO, are you willing to do so?.....YES  NO
8. Do you require managers/supervisors to attend training, educational programs/seminars or staff meetings covering employer/employee relations within a 12 month period?.....YES  NO   
( Hiring/Firing  Basic Supervisory Skills  ADA  FMLA  Harassment  Discrimination)  
If NO, are you willing to do so?.....YES  NO
9. Do you have an attorney advising on employment practices?.....YES  NO   
If YES, please identify the firm's name, address and phone number on a separate sheet.  
*Data for informational purposes only. Defense counsel not authorized unless approved in advance.*
10. Do you have a method and practice of updating your policies/procedures to meet changes in the legal climate and distributing on an annual basis?.....YES  NO   
If NO, are you willing to do so?.....YES  NO
11. Do you require all terminations to be reviewed by a central source:
 

Human Resources Department?.....YES <input type="checkbox"/> NO <input type="checkbox"/>	
Outside Risk Management or Legal Counsel?.....YES <input type="checkbox"/> NO <input type="checkbox"/>	
If other, please give name and title? _____	
If NO, are you willing to do so?.....YES <input type="checkbox"/> NO <input type="checkbox"/>	

**ADDITIONAL COVERAGES** No response in Section E will constitute no interest in these coverages:

- **Third Party Liability** YES  NO   
 (Actual or alleged acts of discrimination/harassment by your employee against a customer/client/former customer)  
 If "yes", please complete the supplemental third party questionnaire and attach to this application.

*All requests subject to underwriter review and approval. Please refer to policy for actual wording and coverage features.*

**Subjectivity Completion Acknowledgement**

As a condition of purchase, it is hereby understood and agreed that the Applicant will implement or has implemented the following subjectivities. The Applicant agrees to complete the subjectivities for any and all Additional Insured's and/or Additional Locations and notify underwriters within 30 days after the effective date. The Applicant must check either **TBI** (To Be Implemented) or **CIP** (Currently In Place) for each subjectivity. If any Additional Insured(s) and/or Additional Location(s) are requested to be covered by this Policy, the Supplemental Questionnaire Additional Insured(s) / Location(s) must be completed for confirmation of the implementation of these subjectivities.

- | <u>TBI</u>               | <u>CIP</u>               |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Employee Handbook or Policies/Procedures must contain the following:  |
| <input type="checkbox"/> | <input type="checkbox"/> | a) Equal Opportunity Statement <i>(see question #5 on page 3)</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | b) "At Will" language <i>(see question #5 on page 3)</i>   |
| <input type="checkbox"/> | <input type="checkbox"/> | c) Sexual Discrimination/Harassment Policy <i>(see question #4 on page 3)</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | d) Open Door/Grievance Policy <i>(see question #4 on page 3)</i>   |
| <input type="checkbox"/> | <input type="checkbox"/> | e) "Not an employment contract" language <i>(see question #4 on page 3)</i>  |
| <br>                     | <br>                     | 2. Insured must confirm the following:   |
| <input type="checkbox"/> | <input type="checkbox"/> | a) Centralized control and review for all terminations/demotions/discipline<br><i>(See question #11 on page 3)</i>   |
| <input type="checkbox"/> | <input type="checkbox"/> | b) Training/seminars/staff meetings with managers/supervisors within a 12-month period regarding employer/employee relations <i>(see question #8 on page 3)</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | c) Distribution of an Employee Handbook or the Policies/Procedures (insured must obtain signed acknowledgement from employee) <i>(see question #5 on page 3)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | d) Use of Dept. of Labor FMLA notifications for FMLA leave (where applicable)<br><i>(See question #7 on page 3)</i>  |

It is understood and agreed that should the Applicant or any Additional Insured(s) and/or Additional Location(s) not fulfill the subjectivity(ies) as defined within 30 days after the effective date, beginning with the first insuring agreement, or any reasonable extension agreed to in writing by Underwriters, that coverage may be jeopardized for any Claim which arises out of the failure to fulfill such subjectivity(ies). It is also understood that failure to complete the subjectivities as defined within the time period may subject the Policy and its coverage terms to retroactive cancellation. The Applicant agrees to work with the designated risk management company assigned to this insurance product. All other designated terms and conditions of this Policy remain unchanged.

**CHECKLIST**

Although the insuring process may have been initiated using copies, the original ESI application must be received and approved by our office within 30 days of effective date:

Have you included:

- 1. ESI Application signed and dated by Principal, Partner or Officer
- 2. ESI Supplemental Questionnaire Additional Insured(s) / Location(s)
- 3. Copy of Employee Handbook  
The last date your handbook was reviewed/updated. \_\_\_\_\_ Month \_\_\_\_\_ Year
- 4. Employment Application
- 5. Further Claims information and detail (if any)

Do you agree to notify underwriters if:

- 5. There is a change to the number of employees of 20% or more? ..... YES  NO
- 6. There are new classes of Employees, subsidiaries, affiliated companies or new acquisitions/mergers?..... YES  NO
- 7. If any Additional Insured(s) and/or Additional location(s) are added? ..... YES  NO

*In the event of above changes, the Applicant must notify Underwriters within 30 days. The Insurer reserves the right to amend the premium and coverage upon notification of such changes.*

The Applicant warrants to the best of its knowledge and belief that the statements set forth herein are true and include all material information, and that there has been no attempt at suppression or misstatement of any material facts known, or which should be known. The Applicant further warrants that if the information supplied on this application changes between the date of this application and the inception date of the Policy, the Applicant will immediately notify underwriters of such change prior to inception of the Policy. Signing of this application does not bind the Insurer to an offer nor the Applicant to accept insurance. The Applicant understands and agrees that this Application and any other previous applications, along with any attachments and supplied information thereto shall be a material and integral part of the Policy and any part of any Policy that may be issued by the Insurer, and the statements made herein shall be construed as representations and warranties of the Applicant.

Applicant further understands and agrees that no person or entity other than Insurer or Applicant has the right to waive or change any part of the Policy. Furthermore, notice to any agent or knowledge possessed by any agent or other persons acting on behalf of the Applicant shall not effect a waiver or a change in any part of the Policy nor estop Insurer from asserting any right under the terms of the Policy

This application is for a "CLAIMS MADE & REPORTED" BASIS POLICY which limits liability to claims first made against an Insured during the Policy Period. Coverage, if completed, may not apply to any known Discrimination, Harassment and Inappropriate Employment Conduct that occurred before the inception of the Policy Period. The Applicant agrees that in the event of covered claims, the Applicant will be required to be defended by the Insurance Company's appointed Attorneys and that the deductible under the Policy shall apply to claims and including (whether or not loss payment is made) investigations costs, and defense fees. If however, the Applicant elects to handle a claim without in any way involving the Insurance Company's Attorneys, then no coverage for such a claim is afforded the Applicant under the Policy.

By signing this Application form, the Applicant confirms that they have been provided with and inspected a specimen of the ESI-EPL Employment Practice Insurance wording. It is recommended that the Applicant take time to review the Policy to ensure that they fully understand the coverages provided. The Applicant should feel free to consult with any source, including legal advisors, regarding coverage.

**In addition to all other terms and conditions:**

**Applicable in Kentucky.** Any person who knowingly and with intent to defraud any insurance company or other 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.

**Limits Requested:**

- \$250K/\$250K
- \$500K/\$500K
- \$500K/\$1M
- \$1M/\$1M
- \$1M/\$2M
- \$1M/\$3M
- \$2M/\$2M
- \$2M/\$4M
- \$5M/\$5M
- \$5M/\$10M
- Other \_\_\_\_\_

**Deductible:**

- \$2500
- \$5000
- \$7500
- \$10K
- \$15K
- \$20K
- \$25K
- \$50K
- Other \_\_\_\_\_
- \$2.5K/\$5K Aggregate
- \$5K/\$10K Aggregate
- \$10K/\$20K Aggregate
- \$25K Aggregate
- \$50K Aggregate
- Other \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's authorized signature of a Principal Partner or Officer

SECTION 6