



# EPC-EMPLOYMENT PRACTICES LIABILITY INSURANCE (EPLI) APPLICATION

Claims First Made & Reported Policy

PROFESSIONAL LIABILITY INSURANCE SERVICES®, INC.  
UNDERWRITING FACILITY - SINCE 1983

P: 800.761.7547 | F: 512.327.5834 | E: UNDERWRITING@PLISINC.COM | W: WWW.PLISINC.COM

## SECTION A: COMPANY INFORMATION

1. Name of Company seeking coverage (include dba if applicable): \_\_\_\_\_  
(This Company will be the name identified on the Declaration page as the Named Insured) NOTE: Complete the Additional Insured Supplement Questionnaire for any additional entities for which coverage is sought.

2.  Sole Proprietor     Corporation     Partnership     Joint Venture     LLC     LLP     Other: \_\_\_\_\_

3. Is this a franchise?..... YES  NO

4. Mailing Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ County: \_\_\_\_\_

If more than one, provide schedule of locations and include the number of employees at each location.

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Website: \_\_\_\_\_

5. Provide the following information for each contact type:

Type	Name	Phone	Email
Management Contact			
Human Resource Contact			

6. Provide name of partners/joint ventures/shareholders/members/individual(s) with majority ownership interest along with ownership percentage of each:

Name: _____	_____ %	Name: _____	_____ %
Name: _____	_____ %	Name: _____	_____ %
Name: _____	_____ %	Name: _____	_____ %

7. Are there any other entity(s) for which you or anyone identified here have a majority ownership interest in that participate in this program?..... YES  NO

a) If yes, provide the name of the entity(s): \_\_\_\_\_

8. Describe Nature of Business: \_\_\_\_\_

9. How long have you been in business? \_\_\_\_\_ How long under current management? \_\_\_\_\_

10. Any merger or acquisition or sale of the company or any of its assets in the past 12 months or expected in the next 12 months?..... YES  NO

If YES, complete the Mergers & Acquisitions Supplemental Questionnaire

11. Gross Sales or Receipts

	For Year Ended (mm/dd/yy)	Amount of Profit or Loss
Past financial year	\$ _____	Net profit <input type="checkbox"/> Net loss <input type="checkbox"/>
Present financial year	\$ _____ est.	Net profit <input type="checkbox"/> Net loss <input type="checkbox"/>
Next financial year	\$ _____ est.	

12. Total number of employees for all locations and, if applicable, Additional Insureds (including Partners, Directors and Officers, Regular Employees, Independent Contractors/1099, Temporary/Leased Employees, Seasonal Employees, Union Employees, Foreign Employees): \_\_\_\_\_

13. Of the total stated on question 12 above, please indicate the status below:

	Partners, Directors & Officers	Regular Employees	*Independent Contractors/1099	Temp/Leased Employees	Seasonal Employees	**Union Employees	Foreign Employees (outside the U.S.)
Full Time							
Part Time							

\*Please note outside companies & vendors are not considered independent contractors/1099. If coverage is desired for independent contractors/1099, provide the name(s) of independent contractors/1099s currently utilized, as well as a copy of the independent contractor/1099 agreement/contract. \*\*If union employees, provide copy of union agreement.

14. Agreements/Contracts – Please indicate any that apply. If yes to any, provide a copy of the document:

a) Written employment agreements or contracts with Partners, Directors or Officers?..... YES  NO

b) Written employment contracts/agreements with Regular Employees?..... YES  NO

If YES, how many: \_\_\_\_\_

c) Utilization of a third-party HR service, or have a relationship with a PEO or co-employer?..... YES  NO

i) If YES, please provide the name of company for which services are utilized or the relationship had: \_\_\_\_\_

15. Please indicate the percentage (%) for each category of employees, the total must equal 100%:

Exempt Employees: \_\_\_\_\_ %    Non-Exempt Employees : \_\_\_\_\_ %    Commission Employees: \_\_\_\_\_ %

16. Salary ranges (including bonuses & commissions):

\$20,000 or less  
\$20,001 to \$50,000

No. of F/T	No. of P/T

\$50,001 to \$100,000  
\$100,001 and over

No. of F/T	No. of P/T

17. How many employees, partners, directors or officers have voluntarily resigned or been terminated in the past year? *If any partners, directors or officers, provide brief explanation of termination.*

Terminated by employer	Employees:	Partners:	Directors:	Officers:
Resigned voluntarily	Employees:	Partners:	Directors:	Officers:

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

19. Any downsizing, reorganization or reduction in force, in the past 12 months or expected in the next 12 months?..... YES  NO   
*If YES, complete the Downsizing Supplemental Questionnaire.*

20. Current EPL insurance:

Year:	Renewal Date:	Carrier:	Limit:	Deductible:	Premium:

a) identify whether:  stand-alone  bundled with other coverage

21. Has any carrier/insurer ever canceled or non-renewed your EPL coverage?..... YES  NO

If YES, please explain: \_\_\_\_\_

22. Do you have public work or government contracts?..... YES  NO

If YES, provide a copy of the agreements & description of services \_\_\_\_\_

23. Do you currently have an Affirmative Action Program? ..... YES  NO

If YES, indicate if it is a result of:  government contracts  EEOC Compliance (*If checked, please provide brief explanation*)  
 voluntary  union agreement  Other: \_\_\_\_\_

**SECTION B: COVERAGE A EMPLOYMENT PROCEDURES**

24. Do you have a Human Resources or Personnel Department?..... YES  NO

25. Do you require all terminations to be reviewed by a central source (HR, Outside Risk Management or Legal Counsel)?..... YES  NO

26. Do you publish, whether in hard copy or electronically, an Employment Handbook?..... YES  NO

a) If yes, provide date Handbook last updated: \_\_\_\_\_

b) If no, if you do publish, whether in hard copy or electronically, policies and procedures (set forth in question 27 below) in some other manner, please describe: \_\_\_\_\_

27. Please indicate whether the following policies contained in the Employment Handbook or otherwise published in writing, whether in hard copy or electronically, are provided to each individual employee:

- a) Equal Opportunity Statement YES  NO
- b) Open Door/Grievance Policy YES  NO
- c) "At Will" language YES  NO
- d) "Not an employment contract" language YES  NO
- e) Sexual Discrimination/Harassment Policy YES  NO
- f) Family Medical Leave Act Policy YES  NO

28. Are employee signatures and/or acknowledgments obtained on handbook and/or policies?..... YES  NO

29. Is an Employment Application used? *If yes, please answer the 29 a) and 29 b). If no, please explain using 29 c).*..... YES  NO

a) Does the application Include an At-Will Statement?..... YES  NO

b) Does the application Include an Equal Opportunity Statement?..... YES  NO

c) If no to either a or b above, please explain \_\_\_\_\_

30. Do you utilize written Arbitration Agreements? (*If yes, please provide a copy*)..... YES  NO

31. Do you post/publish required Dept. Of Labor FMLA notifications to employees regarding FMLA leave? ..... YES  NO

32. Do you require all employees, including management and supervisory employees to attend annual training, educational programs/seminars or staff meetings that cover employer/employee relations?..... YES  NO

*If YES, indicate all that apply:*

Hiring/Firing  Basic Supervisory Skills  ADA  FMLA  Harassment  Discrimination  Other \_\_\_\_\_

**SECTION C: COVERAGE B & COVERAGE C (Third Party) Employment Procedures**

33. Please indicate if the following third-party procedures are in place:

- a) Do you provide customer/client relations training to employees?..... YES  NO
- i) *If YES, is the training conducted as a part of a formalized course?*..... YES  NO
- b) Do you have documented guidelines for accepting/rejecting clients or client relationships? ..... YES  NO
- c) Do you have written procedures for handling complaints made by third parties of discrimination and/or harassment?..... YES  NO
- d) Do you record all complaints of discrimination and/or harassment?..... YES  NO
- e) Do you record or monitor telephone calls?..... YES  NO
- f) Do you have a written business use technology ownership policy? (i.e., fax, email, internet)..... YES  NO

**SECTION D: FAIR LABOR STANDARDS ACT (WAGE & HOUR) (by endorsement) Provide details for any NO response for 34-38**

34. Does your company retain payroll records for all employees for the past 3 years?..... YES  NO

35. Does your company retain all time sheets, time cards or time records for non-exempt employees for the past 3 years?..... YES  NO

36. Do you offer paid sick leave, if required by state law or local ordinance?..... YES  NO  N/A

37. Do you document time off for meal periods of thirty (30) minutes or more, for non-exempt employees, if required by state law or local ordinance?..... YES  NO  N/A
38. Does your Company provide wage statements for every employee for each pay period that are in compliance with your state's regulations?..... YES  NO  N/A
39. Do you deduct from wages for uniforms, tools, breakages, shortages, if not prohibited by state law or local ordinance?..... YES  NO  N/A
- If YES, provide details: \_\_\_\_\_

**SECTION E: LOSS HISTORY**

**LOSS HISTORY FOR COVERAGE A**

40. 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. If yes, to any question below, please complete the Claim Supplement.
- |   |  |  |  |
|---|--|--|--|
| a) Title VII Civil Rights Act of 1964/1991 (EEOC)   | YES <input type="checkbox"/> NO <input type="checkbox"/> | b) National Labor Relations Board                                  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| c) Harassment Claims (EEOC)   | YES <input type="checkbox"/> NO <input type="checkbox"/> | d) U.S. Department of Labor (including FMLA)                       | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| e) Americans with Disabilities Act (EEOC, Department of Justice, Department of Labor or State Agency) | YES <input type="checkbox"/> NO <input type="checkbox"/> | f) IRCA - Immigration Reform & Control Act (Department of Justice) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| g) Age Discrimination in Employment Act   | YES <input type="checkbox"/> NO <input type="checkbox"/> | h) Fair Labor Standards Enforcement Act (Federal or State Agency)  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| i) Department of Fair Employment & Housing (California only)  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| j) Any state or local government agency such as the Labor Department or State Fair Employment Agency? | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| k) Any employment related retaliation or tort claim, lawsuit or hearing?                              | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
41. Have you had any written or oral complaints, claims and/or allegations of discrimination, harassment, retaliation, wrongful termination or any other inappropriate adverse employment action in the last 5 years?..... YES  NO
- a) *If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each*
42. Does any Partner, Director, Officer, Management or Supervisory employee, have knowledge of any fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s) as of the date this Application is signed, which could reasonably give rise to a claim and/or allegation? YES  NO
- a) *If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each.*
- b) *If YES, have you reported such fact(s), circumstance(s), situation(s), transaction(s), event(s), lawsuit(s), potential claim(s) or claim(s) to your current or prior carrier?..... YES  NO*

**LOSS HISTORY FOR COVERAGE A**

*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:*

- i) Making a complaint to a supervisor or management of discrimination, harassment or unfair employment practices; or
- ii) Threatening to hire an attorney or submission of a demand letter; or
- iii) Submitting a written request to toll or waive any statute of limitation; or
- iv) Requesting or demanding that discrimination, harassment, or unfair treatment cease; or
- v) Frequent complaining of discrimination, harassment or unfair treatment to other employees.

**LOSS HISTORY FOR COVERAGES B & C**

43. Have you had any claims and/or allegations of discrimination and/or harassment from a third-party in the last five years? ..... YES  NO
- a) *If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each.*
44. Have you ever been cited for an ADA violation? *If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each.*..... YES  NO
45. Have you ever had an ADA complaint? *If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each.*..... YES  NO
46. Does any Partner, Director, Officer or Management or Supervisory employee, have knowledge of any fact(s), circumstance(s), situation(s), transaction(s), event(s), potential claim(s) or claim(s) as of the date this Application is signed, which could reasonably give rise to a third-party claim?..... YES  NO
- a) *If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each.*
- b) *If YES, have you reported such fact(s), circumstance(s), complaint(s), lawsuit(s) or claim(s) to your current or prior carrier?..... YES  NO*

**LOSS HISTORY FOR COVERAGES B & C**

*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 third party (other than an employee, director, officer, manager, owner) has expressed dissatisfaction by:*

- i) Making a verbal or written complaint of discrimination or harassment to management or supervisory employee; or
- ii) Threatening to hire an attorney or submission of a demand letter.

**LOSS HISTORY FOR Fair Labor Standards Act (Wage & Hour) (by endorsement):**

47. Have you had any claims or potential claims and/or allegations of wage and hour violations in the last 5 years, including but not limited to claims before state labor commissions or Department of Labor Standards Enforcement?..... YES  NO
- a) *If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each*
48. Does any Partner, Director, Officer or Management or Supervisory employee, have knowledge of any fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s) as of the date this Application is signed, which could reasonably give rise to a wage and hour violation and/or allegation?..... YES  NO
- a) *If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each*
- b) *If YES, have you reported such fact(s), circumstance(s), complaint(s), lawsuit(s) or claim(s) to your current or prior carrier?..... YES  NO*

**LOSS HISTORY FOR Fair Labor Standards Act (Wage & Hour) (by endorsement):**

*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 has expressed dissatisfaction with the employment relationship by:*

- i) Making a complaint to management of misclassification, failure to reimburse expenses, failure to provide accurate wage statement(s), failure to pay reporting time, failure to provide meal or rest breaks, retaliation for complaining of such alleged violations.

*It is agreed that if any Partner, Director, Officer, Management or Supervisory employee has knowledge, or if it is reasonable that the person have knowledge, of any such complaints, claim(s), fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s), requested in Section E of this Application: Loss History, any lawsuit or Claim subsequently made arising from such complaints, claim(s), fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s) is not covered under the insurance being applied for by this Application.*

\_\_\_\_\_  
Initials

**The Insured should review and reference the Policy wording for the complete terms, conditions and exclusions of the Policy.**

*Neither the Policy nor the Fair Labor Standards Act of 1938 and Wage Claim Defense Sublimit Endorsement applies to any wage Claim made:*

- *by multiple employees in the same charge, demand or lawsuit; or*
- *by one employee on behalf of others similarly situated; or*
- *as a representative action; or*
- *as a class action, whether certified or uncertified.*

\_\_\_\_\_  
Initials

*Multi-plaintiff or class action lawsuits alleging third party harassment or discrimination, whether certified or not, are excluded.*

\_\_\_\_\_  
Initials

**NOTICE:**

The Applicant represents to the best of its knowledge and belief that the statements set forth 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, which might affect the judgment of the Insurer in its rating and/or acceptance of this risk.

The Applicant agrees that if a contract of insurance is provided by the Insurer, this Application and any other previous Applications, along with any additional supplemental applications, any attachments and supplied information shall be the basis for the formation of such contract and shall be a material and integral part of the Policy, whether or not they are attached to the Policy and/or signed by the Applicant.

Any representations made in the application process for any Policy that may be issued by the Insurer, and the statements made within this Application, any additional supplemental applications, any attachments and supplied information shall be construed as representations of the Applicant.

The Applicant represents that the person signing and initializing this Application and any additional supplemental applications has been authorized to do so by the Applicant.

Signing of this Application and any additional supplemental applications does not bind the Insurer to an offer nor the Applicant to accept insurance.

The Applicant further agrees that if the information supplied on this Application, any additional supplemental applications, any attachments and supplied information changes between the date of this Application and the inception date of the Policy, the Applicant will immediately notify the Insurer of such change prior to inception of the Policy. \_\_\_\_\_ (Initials)

Applicant further understands and agrees that no person or entity other than the Insurer has the right to waive or change any part of the Policy. Furthermore, notice to any broker or knowledge possessed by any broker or other persons acting on behalf of the Applicant shall not affect 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, any additional supplemental applications, any attachments and supplied information is for a "CLAIMS MADE & REPORTED" BASIS POLICY which limits coverage to Claims first made against an Applicant during the Policy Period and reported to the Insurer within the required time period. Coverage, if mutually accepted by the Insurer and the Applicant, will not apply to any known discrimination, harassment, retaliation, wrongful termination or any other inappropriate adverse employment action 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 Insurer's appointed attorneys and that the deductible under the Policy shall apply to Claims including but not limited to defense costs. If, however, the Applicant elects to handle a Claim without in any way involving the Insurer, then no coverage for such Claim is afforded to the Applicant under the Policy.

By signing this Application, and any additional supplemental applications, the Applicant confirms that they have been provided with and inspected a specimen of the EPC - Employment Practices Liability Insurance (EPLI) wording and any applicable endorsements. The Insurer expects that the Applicant will 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.

As a condition of purchase, it is hereby understood and agreed that the Applicant will implement or has implemented the program subjectivities. It is understood and agreed that should the Applicant not fulfill the subjectivity(ies) as defined within 30 days from the effective date or any reasonable extension agreed to in writing by the Insurer, 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 be voided (meaning coverage never existed). The Applicant agrees to work with the designated risk management company assigned to this insurance program.

**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.

\_\_\_\_\_  
Applicant's Authorized Signature of a Principal, Partner or Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant's Signature and Job Title



# EPC-EPLI CLAIM/POTENTIAL CLAIMS SUPPLEMENT

PROFESSIONAL LIABILITY INSURANCE SERVICES®, INC.  
UNDERWRITING FACILITY - SINCE 1983

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- Name of Company (per question 1 on the application) \_\_\_\_\_
- Full name and title of individual(s) involved in the claim / potential claim: \_\_\_\_\_
  - Full name and title of claimant: \_\_\_\_\_
    - The claimant is or was a:
 

<input type="checkbox"/> Partner, Director, Officer	<input type="checkbox"/> Regular Employee	<input type="checkbox"/> Independent Contractor/1099
<input type="checkbox"/> Seasonal Employee	<input type="checkbox"/> Union Employee	<input type="checkbox"/> Foreign Employee
<input type="checkbox"/> Third Party - current or former customer or client	<input type="checkbox"/> Third Party ADA - current or former customer or client	
    - Was the claimant an employee of the applicant?..... YES  NO
    - Was there an employment relationship?..... YES  NO
    - Is the employee still employed by applicant? ..... YES  NO
    - Are other witnesses or involved parties still employed?..... YES  NO
  - Indicate the current status:      Lawsuit       Administrative Proceeding       Demand       Potential Claim 
    - This claim is currently:       Open       Closed      If Open, please provide details: \_\_\_\_\_
    - Description of the alleged act upon which the claimant basis the claim/potential claim. Include events leading to the claim/potential claim. Use additional space on back if the space below is insufficient:  
\_\_\_\_\_  
\_\_\_\_\_
    - List all the allegations identified: \_\_\_\_\_
  - Date of act giving rise to the claim/potential claim:
    - Date claim/potential claim made against the applicant: \_\_\_\_\_
    - Date claim/potential claim was reported to carrier/insurer: \_\_\_\_\_
    - Name of the carrier/insurer the claim/potential claim was reported to: \_\_\_\_\_
    - Was there an attorney involved? ..... YES  NO
    - Was the attorney appointed by the carrier/insurer? ..... YES  NO
  - If the claim / potential claim is still open, answer the following:
    - Claimant's settlement demand: \_\_\_\_\_
    - Current defense costs paid to date: \_\_\_\_\_
    - Carrier/Insurer's defense and/or loss reserves: \_\_\_\_\_
    - Applicant's offer for settlement/estimate of settlement amount: \_\_\_\_\_
    - Carrier/Insurer's offer for settlement/estimate of settlement amount: \_\_\_\_\_
  - If the claim / potential claim is closed, please answer the following:
    - What was the total amount of the settlement or judgement?: \_\_\_\_\_
    - Total amount of the Deductible Applied (if applicable): \_\_\_\_\_
    - Total paid by applicant in excess of deductible (if applicable): \_\_\_\_\_
    - Did the claim settle?                      YES  NO                       Date of Settlement: \_\_\_\_\_
    - Was there a judgment?                      YES  NO                       Date of Judgement: \_\_\_\_\_
    - Do you have a signed settlement/separation agreement?..... YES  NO
  - Was an investigation conducted?.....YES  NO   
If yes, please provide who conducted the investigation: \_\_\_\_\_
  - Explain what action(s) have been taken to prevent a recurrence or to mitigate damages of a similar claim / potential claim:  
\_\_\_\_\_  
\_\_\_\_\_

### NOTICE

The Applicant represents to the best of its knowledge and belief that the statements set forth 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, which might affect the judgment of the Insurer in its rating and/or acceptance of this risk.

**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.

\_\_\_\_\_  
Applicant's Authorized Signature of a Principal, Partner or Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant's Signature of a Principal, Partner or Officer





# EPC-EPLI ADDITIONAL INSURED(S) SUPPLEMENT

Page 1: Questionnaire

PROFESSIONAL LIABILITY INSURANCE SERVICES®, INC.  
UNDERWRITING FACILITY - SINCE 1983

P: 800.761.7547 | F: 512.327.5834 | E: UNDERWRITING@PLISINC.COM | W: WWW.PLISINC.COM

If any Additional Insured is requested to be covered by this Policy, this Supplemental Questionnaire must be completed. Further, if the Additional Insured(s) was the result of a Merger or Acquisition in the past 12 months, then the Merger & Acquisition Supplemental Questionnaire will need to be completed as well.

Name of Company (per question 1 on the application): \_\_\_\_\_

*You must complete the second page of this supplement indicating each Additional Insured for which coverage is sought.*

1. Do all employees of the identified Additional Insured(s) follow the main Company's same Employment Procedures?..... YES  NO

**If no, please answer the following; if yes, skip to question 2.**

a) Does each Additional Insured have its own separate employment handbook and/or policies/procedures?..... YES  NO

b) Does each Additional Insured have its own application?..... YES  NO

*If YES to either, Please Attach a Copy of Each.*

2. Has the Additional Insured(s) had any written or oral complaints, potential claim(s), claim(s) and/or allegations of discrimination, harassment retaliation, wrongful termination or any other inappropriate adverse employment action in the last 5 years?..... YES  NO

*If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each*

3. Does any Partner, Director, Officer, Management or Supervisory employee of the Additional Insured have knowledge of any fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s) which could reasonably give rise to a Claim and/or allegations?..... YES  NO

a) *If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each.*

b) *If YES, have you reported such fact(s), circumstance(s), complaint(s), lawsuit(s) or claim(s) to your current or prior carrier?..... YES  NO*

4. If any other information from the Additional Insured(s) differs from the Company, please state the difference here:

\_\_\_\_\_  
\_\_\_\_\_

*It is agreed that if any Partner, Director, Officer, Management or Supervisory employee has knowledge, or if it is reasonable that the person have knowledge, of any such complaints, claim(s), fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s), requested in this supplemental questionnaire application, any lawsuit or Claim subsequently made arising from such complaints, claim(s), fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s) is not covered under the insurance being applied for by this Application.*

Initials

### NOTICE

Please be aware that newly formed or acquired organization(s) are not covered for any claim that results from any event that happened or first commenced before the Applicant acquired or formed it; nor for any claim covered under any other insurance. Also, once the information requested on this Supplement Questionnaire has been received and reviewed by the Insurer, terms may change and/or additional subjectivities may be required to secure coverage for that newly formed or acquired organizations.

The Applicant, represents on behalf of each and every proposed insured under the Policy, to the best of its knowledge and belief that the statements set forth 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, which might affect the judgement of the Insurer in its rating and/or acceptance of this risk.

It is hereby understood and agreed that the Applicant will implement or has implemented the program subjectivities for any Additional Insured's. It is also understood and agreed that should the Applicant or any Additional Insured(s) not fulfill the subjectivity(ies) as defined within 30 days after the effective date, or any reasonable extension agreed to in writing by the Insurer, that coverage may be jeopardized for any Claim which arises out of the failure to fulfill such subjectivity(ies). Further, it is also understood that failure to complete the subjectivities may subject the Policy and its coverage terms to be voided (meaning coverage never existed). The Applicant and any Additional Insured(s) agrees to work with the designated risk management company assigned to this insurance product.

**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.

\_\_\_\_\_  
Applicant's Authorized Signature of a Principal, Partner or Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant's Signature of a Principal, Partner or Officer



### EPC-EPLI ADDITIONAL INSURED(S) SUPPLEMENT

Page 2: Schedule of Entity(s) & DBA name(s) (Use multiple copies as necessary)

Provide a schedule of locations and if more than one location per additional entity, include the number of employees at each location.

Name of Company (per question 1 on the application): \_\_\_\_\_

Name of Additional Entity and/or DBA: \_\_\_\_\_ Nature of Business and Date Entity and/or DBA Established: \_\_\_\_\_  
 Physical Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Website: \_\_\_\_\_  
 County: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Provide name of partners/joint ventures/stockholders/name of individual with majority ownership interest along with ownership percentage:  
 Name: \_\_\_\_\_ % Name: \_\_\_\_\_ %  
 Name: \_\_\_\_\_ % Name: \_\_\_\_\_ %  
 Employee count for additional entity: \_\_\_\_\_

	Partners, Directors & Officers	Regular Employees	*Independent Contractors/1099	Temp/Leased Employees	Seasonal Employees	**Union Employees	Foreign Employees (outside the U.S.)
Full Time							
Part Time							

Name of Additional Entity and/or DBA: \_\_\_\_\_ Nature of Business and Date Entity and/or DBA Established: \_\_\_\_\_  
 Physical Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Website: \_\_\_\_\_  
 County: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Provide name of partners/joint ventures/stockholders/name of individual with majority ownership interest along with ownership percentage:  
 Name: \_\_\_\_\_ % Name: \_\_\_\_\_ %  
 Name: \_\_\_\_\_ % Name: \_\_\_\_\_ %  
 Employee count for additional entity: \_\_\_\_\_

	Partners, Directors & Officers	Regular Employees	*Independent Contractors/1099	Temp/Leased Employees	Seasonal Employees	**Union Employees	Foreign Employees (outside the U.S.)
Full Time							
Part Time							

Total Number of Employees for all additional entities listed above (employee counts must equal total noted on page one of the application): \_\_\_\_\_  
 (Use multiple copies as necessary)

This supplemental information is not intended to be a representation of coverage or a guarantee of a quote or indication. See policy wording for coverage details.

\*Please note outside companies & vendors are not considered independent contractors/1099s. If coverage is desired for independent contractors/1099s, provide the name(s) of independent contractors/1099s currently utilized, as well as a copy of the independent contractor/1099 agreement/contract. \*\*If union employees, provide copy of union agreement.



PROFESSIONAL LIABILITY INSURANCE SERVICES®, INC.  
 UNDERWRITING FACILITY - SINCE 1983

P: 800.761.7547

F: 512.327.5834

E: UNDERWRITING@PLISINC.COM

W: WWW.PLISINC.COM

# EPC-EPLI SCHEDULE OF LOCATIONS & EMPLOYEE COUNT

FOR THE COMPANY AS NOTED ON QUESTION ONE OF THE APPLICATION

Schedule of Locations (Street/City/State/Zip Code)	Full Time Employees	Part Time Employees	Seasonal Employees	Leased/Temp Employees	Contract Employees	*Independent Contractors/1099	**Union Employees	Foreign Employees (Outside the US)
1. Address								
2. Address								
3. Address								
4. Address								
5. Address								
6. Address								
7. Address								
8. Address								
9. Address								
10. Address								
<b>Total Number of Employees:</b> (Employee counts to equal the total noted on page one of the Application.) (Use multiple copies as necessary)								

\*\*Please note outside companies & vendors are not considered independent contractors/1099s. If coverage is desired for independent contractors/1099s, provide the name(s) of independent contractors/1099s currently utilized, as well as a copy of the independent contractor/1099 agreement/contract. \*\*If union employees, provide copy of union agreement.







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:

- i) Making a complaint to a supervisor or management of discrimination, harassment or unfair employment practices; or
- ii) Threatening to hire an attorney or submission of a demand letter; or
- iii) Submitting a written request to toll or waive any statute of limitation; or
- iv) Requesting or demanding that discrimination, harassment, or unfair treatment cease; or
- v) Frequent complaining of discrimination, harassment or unfair treatment to other employees.

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 third party (other than an employee, director, officer, manager, owner) has expressed dissatisfaction by:

- i) Making a verbal or written complaint of discrimination or harassment to management or supervisory employee; or
- ii) Threatening to hire an attorney or submission of a demand letter.

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 has expressed dissatisfaction with the employment relationship by:

- i) Making a complaint to management of misclassification, failure to reimburse expenses, failure to provide accurate wage statement(s), failure to pay reporting time, failure to provide meal or rest breaks, retaliation for complaining of such alleged violations

*It is agreed that if any Partner, Director, Officer, Management or Supervisory employee has knowledge, or if it is reasonable that the person have knowledge, of any such complaints, claim(s), fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s), of this supplemental questionnaire application, any lawsuit or Claim subsequently made arising from such complaints, claim(s), fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s) is not covered under the insurance being applied for by this Application.*

Initials

NOTICE

The Applicant, represents on behalf of each and every proposed insured under the Policy, to the best of its knowledge and belief that the statements set forth 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, which might affect the judgment of the Insurer in its rating and/or acceptance of this risk.

The Applicant, on behalf of each and every proposed insured under the Policy, understands that all of the above information, any attachments, and supplied information become part of and subject to all the terms, conditions, and exclusions of the EPC - Employment Practices Liability Insurance (EPLI) Policy.

Please be aware that any acquired or formed organization is not covered for any claim that results from any event that happened or first commenced before the Applicant acquired or formed it; nor for any claim covered under any other insurance. Please be aware that newly merged or acquired organization(s) are not covered for any claim that results from any event that happened or first commenced before the Applicant merged with or acquired it; nor for any claim covered under any other insurance.

Also, once the information requested on this Supplement has been received and reviewed by the Insurer, terms may change and/or additional subjectivities may be required to secure coverage for that newly merged or acquired organizations.

**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.

\_\_\_\_\_  
Applicant's Authorized Signature of a Principal, Partner or Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant's Signature of a Principal, Partner or Officer



# EPC-EPLI DOWNSIZING SUPPLEMENT

PROFESSIONAL LIABILITY INSURANCE SERVICES®, INC.  
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**Complete if any downsizing or reduction in force occurred in the past 12 months or is expected in the next 12 months**

- Name of Company (per question 1 on the application) \_\_\_\_\_
1. Date of downsizing or reduction in force (RIF): \_\_\_\_\_
  2. Provide details regarding the downsizing or RIF: \_\_\_\_\_
  3. Select which applies to the downsizing or RIF:  Acquisition  Consolidation  Merger  Dissolution  Reformation  
 Other (please describe): \_\_\_\_\_
  4. How many employees affected and at which location? \_\_\_\_\_
  5. How many Partners, Directors or Officers were or will be terminated/laid off? \_\_\_\_\_
    - a) How many severance packages offered? \_\_\_\_\_
    - b) How many severance packages accepted? \_\_\_\_\_
    - c) Were/will severance agreements/releases be obtained? ..... YES  NO   
If YES, how many? \_\_\_\_\_
  6. How many employees were or will be terminated/laid off? \_\_\_\_\_
    - a) How many severance packages offered? \_\_\_\_\_
    - b) How many severance packages accepted? \_\_\_\_\_
    - c) Were/will severance agreements/releases be obtained? ..... YES  NO   
If YES, how many? \_\_\_\_\_
  7. How many employees were retained? \_\_\_\_\_
  8. Is or was legal counsel retained for the implementation of the downsizing or RIF? ..... YES  NO   
a) Type of law firm (employment law, corporate, etc) \_\_\_\_\_
  9. Have any of the affected employees reported any written or oral complaints, claims and/or allegations of discrimination, harassment, retaliation wrongful termination or any other inappropriate adverse employment action in the last 5 years? ..... YES  NO
  10. Does any Partner, Director, Officer, Management or Supervisory employee at the have knowledge of any Claim(s), fact(s), circumstance(s), situation(s), transaction(s), potential claim(s) or event(s), which could reasonably give rise to a Claim? ..... YES  NO   
a) If YES, how many? \_\_\_\_\_ Please complete the Claim Supplement for each.  
b) If YES, have you reported such fact(s), circumstance(s), complaint(s), lawsuit(s) or claim(s) to your current or prior carrier? ..... YES  NO

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- i) Making a complaint to a supervisor or management of discrimination, harassment or unfair employment practices; or
- ii) Threatening to hire an attorney or submission of a demand letter; or
- iii) Submitting a written request to toll or waive any statute of limitation; or
- iv) Requesting or demanding that discrimination, harassment, or unfair treatment cease; or
- v) Frequent complaining of discrimination, harassment or unfair treatment to other employees.

*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 third party (other than an employee, director, officer, manager, owner) has expressed dissatisfaction by:*

- i) Making a verbal or written complaint of discrimination or harassment to management or supervisory employee; or
- ii) Threatening to hire an attorney or submission of a demand letter.

*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 has expressed dissatisfaction with the employment relationship by:*

- i) Making a complaint to management of misclassification, failure to reimburse expenses, failure to provide accurate wage statement(s), failure to pay reporting time, failure to provide meal or rest breaks, retaliation for complaining of such alleged violations

**It is agreed that if any Partner, Director, Officer, Management or Supervisory employee has knowledge, or if it is reasonable that the person have knowledge, of any such complaints, claim(s), fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s), of this supplemental questionnaire application of the any lawsuit or Claim subsequently made arising from such complaints, claim(s), fact(s), circumstance(s), situation(s), transaction(s), event(s) or potential claim(s) is not covered under the insurance being applied for by this Application.**

\_\_\_\_\_  
**Initials**

NOTICE

The Applicant to the best of its knowledge and belief that the statements set forth 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, which might affect the judgement of the Insurer in its rating and/or acceptance of this risk.

**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.

\_\_\_\_\_  
Applicant's Authorized Signature of a Principal, Partner or Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant's Signature of a Principal, Partner or Officer