

## WORKPLACE VIOLENT ACT INSURANCE APPLICATION

Loss of Business Income, Bodily Injury, Property Damage & Incident Response for Violent Act Events

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1.	Applicant Company Name:							
	□ Sole Proprietor □ Corporation □ Partnership □ Joint Venture □ LLC □ LLP □ Other:							
3.	Describe Nature of Business/Type of Operation:							
4.	Mailing Address:							
	City, State, Zip Code:							
5.	Risk Management/Human Resources Contact Person:							
	Phone: E-mail:							
6.	Total Annual Sales All Locations: Annual Sales of Largest Location:							
7.								
8.	Total employee count (all locations): Full Time Part Time							
9.	Do you have onsite security personnel?	YES 🗖 NO 🗖						
10.	Do you allow weapons and/or firearms in your locations?							
	If YES, please provide under what circumstances you allow weapons and which weapons.							
11.	Do you conduct background checks for all potential employees?							
12.	Are there physical barriers in place to help deter an attack or assault:	YES 🗖 NO 🗖						
	If so, what?							
13.	Hours of Operation: Business Hrs. Mon.—Fri ☐ Business Hours Weekends: ☐ Open 24 Hours.: ☐							
14.	Is your business open to the public?	YES 🗖 NO 🗖						
	If YES, approximately how many non-employees visit your facility each week?							
15.	How frequently do your employees and/or management travel as a part of their job duties?							
16.	Policies and procedures. Do you have the following?							
	a. Workplace Violence Crisis Management/Security Plan?	YES 🗖 NO 🗖						
	b. Workplace Violence Policy Distributed to employees?	YES 🗖 NO 🗖						
	c. Open Door Policy?	YES 🗖 NO 🗖						
	d. Harassment/Sexual Harassment Policy?	YES 🗖 NO 🗖						
	e. Electronic Monitoring Notice Policy?	YES 🗖 NO 🗖						
	f. Third Party/Customer Complaint Policy (Reporting & Handling of Complaints)?	YES 🗖 NO 🗖						
17.	Training. Do you do the following?							
	a. Workplace Violence Training for Employees & Management?	YES 🗖 NO 🗖						
	b. Mock Workplace Violence Drills for Employees & Management?	YES 🗖 NO 🗖						
18.	YES 🗖 NO 🛚							
19.	Do expect any layoffs/reductions in force over the next 12 months or had any in the past 12 months?	YES 🗖 NO 🕻						
20.	a. Planned number of new locations in next 12 months (include expected open date and city/state of new location):							
	b. Planned number of locations to be closed in next 12 months (include expected close date and city/state of location):							
21.	21. Please complete the following for all locations <i>(or, submit in an accompanying Excel Format Spreadsheet or Other Document)</i> :							
	City & State Number of Locations							
	NOTE – A full listing of locations with zip code will be required prior to binding.							
22	In what Metropolitan area (city) do you have the largest Number of Locations:							
	Do you have locations within any of the following:							
20.	a. Airport	YFS D NO D						
	b. Shopping Center/Mall							
	c. Public or Private Schools.							
	d. Hospitals	YES 🗖 NO 🗖						
	e. Military Base(s)							

24.	During the last five years, has any loca				
					YES <b>U</b> NO <b>U</b>
	If YES to any of the above, provide con	mplete the Claims Supplement i	vith dates, details,	and amount of the loss, if applicable.	
0.5	Described in the control of the cont	and a subdividual of the substitute of the subst	San the constant	Karaman kanan kata kata kata kata ka	
25.				If no current coverage is in force, check the box:	
	Carrier:	Coverage: \$			
	Premium: \$	Policy Period:	to	Number of Insured Locations:	
27	Describe information about account limits		h	ad divide a the conset was	
26.	Provide information about current limits				
	Carrier:	Coverage: \$			
	Premium: \$	Policy Period:	to	Number of Insured Locations:	
27	Dravide information about current limits	on Commercial Dranarty Inquir	anaa aarriad durin	a the past year	
27.	Provide information about current limits				
	Carrier:	Coverage: \$			
	Premium: \$	Policy Period:	to	Number of Insured Locations:	
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28.	Provide information about current limits				
	Carrier:	Coverage: \$			
	Premium: \$	Policy Period:	to	Number of Insured Locations:	
00					V50 D NO D
29.					YES 🗖 NO 🗖
	If YES, please provide limit(s)?	<del></del>			
attac and/	nments and supplied information shall be or signed by the Applicant.	the basis for the formation of such	h contract and shal	nd any other previous Applications, along with any additional supp Il be a material and integral part of the Policy, whether or not they ers, and the statements made within this Application, any additional	are attached to the Policy
	ittachments and supplied information shall				очррношона пррпошоно,
The	Applicant represents that the person signin	g and initializing this Application a	and any additional s	supplemental applications has been authorized to do so by the App	olicant.
Sign	ng of this Application and any additional su	upplemental applications does not	bind the Insurer to	an offer nor the Applicant to accept insurance.	
			, ,,	emental applications, any attachments and supplied information ch rs of such change prior to inception of the Policy.	anges between the date of (Initials)
poss				ght to waive or change any part of the Policy. Furthermore, notice or a change in any part of the Policy nor estop Underwriters from as	
Insur		ments. Underwriters expect that the	ne Applicant will tak	that they have been provided with and inspected a specimen of see time to review the Policy to ensure that they fully understand the	•
Unde		ons. The Applicant Company agr	-	gree to use the crisis consultants/risk management services as a contact the designated 24-hour crisis consultants services as def	
	ance containing any materially false inform			gly and with intent to defraud any insurance company or other per ormation concerning any fact material thereto commits a fraudulen	• • • • • • • • • • • • • • • • • • • •
Appl	cant's authorized signature of a Principal, i	Partner or Officer	 Date	Printed Name of Applicant's authorized signature of a Princi	pal, Partner or Officer