

THIS IS AN APPLICATION FOR A CLAIMS-MADE POLICY. THE POLICY PROVIDES NO COVERAGE FOR *CLAIMS* ARISING OUT OF EMPLOYMENT PRACTICES WHICH TOOK PLACE PRIOR TO THE *RETROACTIVE DATE*. THE POLICY COVERS ONLY *CLAIMS* ACTUALLY MADE AGAINST AN *INSURED* WHILE THE POLICY REMAINS IN EFFECT. ALL COVERAGE UNDER THE POLICY CEASES UPON THE TERMINATION OF THE POLICY EXCEPT FOR THE BASIC *EXTENDED REPORTING PERIOD*, OR UNLESS THE *NAMED INSURED* PURCHASES SUPPLEMENTAL *EXTENDED REPORTING PERIOD*. THE LIMITS OF LIABILITY AVAILABLE TO PAY *DAMAGES* OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED AS *CLAIM* *EXPENSES*, INCLUDING FEES AND EXPENSES INCURRED IN THE INVESTIGATION, ADJUSTMENT, AND DEFENSE OF A *CLAIM* FOR LIMITS OF $100,000 OR GREATER. SUCH *CLAIM* *EXPENSES* SHALL ALSO BE APPLIED AGAINST THE DEDUCTIBLE BY THE AMOUNT OR PERCENTAGE STATED IN THE POLICY. PLEASE REFER TO THE POLICY FOR THE EXACT TERMS AND CONDITIONS CONCERNING THE COMPANY’S LIMITS OF LIABILITY.

NOTICE: THESE POLICY FORMS AND THE APPLICABLE RATES ARE EXEMPT FROM THE FILING REQUIREMENTS OF THE NEW YORK STATE INSURANCE DEPARTMENT. HOWEVER, SUCH FORMS AND RATES MUST MEET THE MINIMUM STANDARDS OF THE NEW YORK INSURANCE LAW AND REGULATIONS.

EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION

This is an application for a **“Claims-Made”** policy. The Policy provides no coverage for Claims arising out of employment practices which took place prior to the Retroactive Date. The Policy covers only Claims actually made against an Insured while the Policy remains in effect. The limit of liability available to pay damages or settlements shall be reduced by amounts incurred as “Claim Expenses,” including fees and expenses incurred in the investigation, adjustment, and defense of a claim or multiple claims. The Policy will be issued in reliance upon the statements in the application. Therefore, it is important that all questions be answered accurately.

**Please follow the steps listed below to complete your application for CAMICO coverage:**

* Review all definitions at the bottom of the page.
* Please type or print clearly, and do not use pencil.
* Complete Parts I through VII, answering all questions completely. If any question, or part thereof, does not apply, print “NA” in the space provided - leave no blanks. Failure to answer all questions will delay our ability to underwrite this application, which may result in a gap in your coverage.
* Complete supplemental application(s) only when appropriate.
* Sign on page 6 and make a copy of the completed application for your records.
* Return the completed application (see page 6 for mailing address).

Common Phrases and Definitions

**FIRM**  
The term “Firm” means the entity listed in Part I, question 1 of this application and any individual owner (proprietor, stockholder, partner) and any individual employee of the entity listed in Part I, question 1 of this application.

**PRIOR ACTS**  
Coverage for employment practices prior to inception of this Policy may be requested where the Firm has current employment practices liability coverage.

If this Policy is written with prior acts coverage it shall apply only to claims for damages as a result of employment practices which first take place on or after the prior acts (retroactive) date.

**PART-TIME**  
Persons who work more than 32 hours per week or 1,600 hours per year, even if seasonal, are Full-time. Persons who work less than 32 hours per week or 1,600 hours per year are considered Part-time.

**Part I: Firm Information**

**1.** Firm Name:

**2.** Contact Person:       **3.** Requested Effective Date:

**4.** Title:       **5.** E-mail Address:

**6.** Primary Office Address:

Street Address City County State Zip

***If your Firm operates from any other office location(s), please complete Part I, Question 6, of the EPL Insurance Supplement (E-1).***

**7.** Telephone:       **8.** Fax:       **9.** Web Site:

**10.** Mailing Address:

***(if different from #6)*** Street Address City County State Zip

**11.** Entity Type:  Sole Proprietorship  Partnership  Corporation  LLP  LLC  PC  Other (list):

**12.** Date Firm Established (mm/dd/yyyy):

**13.** List Name(s) of all Partners/Owners.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **% Ownership** | **Title** | **Professional Organization Memberships** | **E-mail Address** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

***Please use Part I, Question 13, of the EPL Insurance Supplement (E-1) if additional room is needed***

**Part II: Firm Profile**

**14.** For the location listed above in Question 6, please list the total number of employees, workers and independent contractors, broken down by Full-Time employees, Part-Time employees, Contract Workers, Leased Workers and Independent Contractors, for each of the last three years (please refer to explanation of staff types below):

*If your Firm operates from any other office location(s), please complete Part II, Question 14, of the EPL Insurance Supplement (E-1).*

***PLEASE DO NOT INCLUDE PARTNERS IN THE FIRM***

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Current Year** | **Prior Year** | **2 Years Ago** |
| **# of Full-Time Employees** |  |  |  |
| **# of Part-Time Employees** |  |  |  |
| **# of Contract Workers** |  |  |  |
| **# of Leased Workers** |  |  |  |
| **# of Independent Contractors** |  |  |  |
| **Total** |  |  |  |

**15.** CAMICO’s Employment Practices Liability Insurance does not include coverage for Independent Contractors unless this coverage is added by endorsement. Please check the “Yes” box if you want to add coverage for Independent Contractors (refer to the table below for an explanation of who constitutes an Independent Contractor).  Yes

***Unless specifically amended by an endorsement, there is no coverage for any claims brought by Independent Contractors. To obtain this endorsement, please complete Part II, Question 15, of the EPL Insurance Supplement (E-1). Please note that an Independent Contractor can never be an “Insured” under your policy.***

**Explanation of Staff Types**

**Full-Time Employee:**

Defined as a person employed by the Named Insured for wages or salary or any non-equity partners of the firm. Employee does not include any Contract Worker, any Independent Contractor, any employee of an Independent Contractor, or any Leased Worker.  
**Part-Time Employee:**

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

Defined as a natural person who contracts directly with the Named Insured to provide professional services on behalf of the Named Insured. For example, a seasonal tax worker performing services for the firm’s clients would be considered a Contract Worker.

**Leased Worker:**

Defined as a person leased to the Named Insured by a labor leasing firm under an agreement between the Named Insured and the labor leasing firm to perform duties related to the conduct of the Named Insured’s business. Leased Worker does not include a Contract Worker.

**Independent Contractors:**  
Defined as independent contractors/per diem workers. For example, a non-employee individual working in a non-client related area, such as IT/telephone/data maintenance, would be considered an independent contractor.

**16.** Breakdown of current Full-Time employees (excluding partners/owners) by their total cash compensation   
(salary + bonus):

***PLEASE DO NOT INCLUDE PARTNERS/OWNERS IN THE FIRM***

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

**17.** Based on your Firm’s fiscal year-end data, please provide the following gross revenue figures

(accrual basis income):

|  |  |  |
| --- | --- | --- |
| **Next Fiscal Year**  **(projected)** | **Current Fiscal Year**  **(estimated)** | **Last Fiscal Year** |
| $ | $ | $ |

**18.** a. Have you had any branch or office closings, consolidations, layoffs or staff reductions (greater

than 10% of the workforce), mergers or acquisitions within the past 24 months?  Yes  No

***If “Yes,” please provide details under Part II, Question 18a, on the EPL Insurance Supplement (E-1).***

b. Do you anticipate any of the above within the next 12 months? Yes  No

***If “Yes,” please provide details under Part II, Question 18b, on the EPL Insurance Supplement (E-1).***

**19.** Involuntary Turnover: Total number of employer-initiated terminations of Full-time and Part-time employees.

Voluntary Turnover: Total number of Full-time and Part-time employees who initiated their own separations and

voluntarily terminated their employment.

***DO NOT INCLUDE SEASONAL WORKERS, RETIREES, INDEPENDENT CONTRACTORS OR INTERNS IN VOLUNTARY TURNOVER COUNT.***

|  |  |  |
| --- | --- | --- |
|  | **Involuntary Turnover:** | **Voluntary Turnover:** |
| Current Year |  |  |
| Previous Year |  |  |
| 2 Years Ago |  |  |

**Part III: Loss History**

**20.** Within the last five years, has the company or any individual proposed for this insurance:

a. received any employment-related inquiry, complaint or charge from any municipal, state, or

federal regulatory authority or any other governmental entity?  Yes  No

b. had a claim, suit, grievance, or demand brought against them?  Yes  No

***If “Yes,” to either a and/or b, please provide details under Part III, Question 20, on the EPL Insurance Supplement (E-1).***

**21.** Are you aware of any facts, incidents, or circumstances that may result in a claim(s) being made

against you?  Yes  No

***If “Yes,” please provide details under Part III, Question 21, on the EPL Insurance Supplement (E-1).***

**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 THEREUNDER. FAILURE TO DISCLOSE SUCH KNOWN FACTS, INCIDENTS OR CIRCUMSTANCES HERE WILL VOID THE PROPOSED POLICY IN ITS ENTIRETY.**

**Part IV: Insurance Information**

**22.** Do you currently carry Employment Practices Liability insurance? Yes  No

***If “Yes,” please attach a copy of your current declarations page and provide:***

|  |  |
| --- | --- |
| Carrier: | Limit (per claim/aggregate): |
| Policy Term: From:       To: | Retroactive Date: |
| Deductible: | Co-Insurance Amount, if any: |
| Premium: |  |

**23.** Has any insurer ever canceled or non-renewed this type of coverage? Yes  No

***If “Yes,” please provide details under Part IV, Question 23, on the EPL Insurance Supplement (E-1).***

**24.** Requested limit of liability and deductible (check all options you wish quoted):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Limit of Liability:**  **Per Claim / Policy Aggregate** | |  | **Deductible** | |
|  | $100,000 / $100,000 |  |  | $5,000 |
|  | $250,000 / $250,000 |  |  | $10,000 |
|  | $500,000 / $500,000 |  |  | $15,000 |
|  | $500,000 / $1,000,000 |  |  | $20,000 |
|  | $1,000,000 / $1,000,000 |  |  | $25,000 |
|  | $1,000,000 / $2,000,000 |  |  |  |

**25.** Do you currently carry PROFESSIONAL LIABILITY INSURANCE?  Yes  No

If “Yes,” Carrier:       Expiration Date:

Limit of Liability:       **Pa**

**Part V: Risk Management Practices**

**26.** Do you make use of any of the following tests to screen employment applicants, to promote employees,

or for the purpose of continuing employment?

a. Psychological or personality tests?  Yes  No

b. Drug or alcohol tests?  Yes  No

c. Pre-employment offer medical tests?  Yes  No

***If “Yes,” please provide details under Part V, Question 26, on EPL Insurance Supplement (E-1).***

**27.** a. Have all your employment-related policies and procedures been reviewed and approved by outside

counsel? Yes  No *If* ***“Yes,” when?***

##### b. Have all recommendations from that review been implemented? Yes No

***If “No,” please explain or provide time frame for implementation under Part V, Question 27b, on the EPL Insurance Supplement (E-1).***

**28.** a. Who is responsible for the Human Resources or Personnel functions?

Name:       Title:       E-Mail:

b. Is this contact the person to whom all employment related incidents are reported?  Yes  No

***If “No,” to whom are these incidents reported?***

c. Do you require that all employment terminations be reviewed by personnel having Human Resource

responsibility?  Yes  No

**29.** Do you distribute an Employee Handbook to your employees?  Yes  No

***If “Yes,”***

a. Do you require employees to acknowledge that they have received and understood the Handbook?    Yes  No

b. Does it contain:   
 i.  an employment-at-will statement?    Not applicable due to our State law  Yes  No

ii. a written equal employment opportunity statement?   Yes  No

iii. a written sexual harassment and other harassment policies?  Yes  No

iv. a written internal complaint procedure for discrimination and sexual harassment claims?   Yes  No

***If “No,”***

c. Do you have written policies on any of the above that are distributed separately?       Yes  No

d. Please specify which policies are distributed separately:

**30.** Do you provide training to your employees, including management, on any of the following employment

practice topics?

a. Sexual Harassment (training must be provided annually),  Yes  No

***If “Yes,” provide the date of your Firms last sexual harassment training:***

b. Discrimination,  Yes  No

c. Americans with Disabilities Act,  Yes  No

d. Family Medical Leave Act,  Yes  No

e. Reporting Incidents of Complaints.  Yes  No

**31.** Do you use an employment application during your hiring process?  Yes  No

***If “Yes,” does it contain:***

a. an employment-at-will statement?  Not applicable due to our State laws  Yes  No

b. authorization to check references and criminal conviction records?  Yes  No

c. the applicant’s signature attesting that all representations are true?  Yes  No

d. an equal employment opportunity statement?  Yes  No

**32.** Management/Supervisor Training

a. Do you have a progressive disciplinary program?  Yes  No

***If “Yes,” has it been distributed to supervisors in writing?***  Yes  No

b. Do you post, in places conspicuous to all employees and applicants for employment, all notices

required by law?  Yes  No

c. When requested by employees, do you distribute information as required by federal law regarding

the Family Medical Leave Act?  Yes  No

d. Have you informed supervisory personnel, in writing, of their responsibility to provide

you with prompt notice of any claims, incidents or allegations?  Yes  No

e. Do you keep supervisors/management continually informed on any changes in employment practices?  Yes  No

**33.** Do employees have a venue for reporting any serious concerns relating to incorrect financial

reporting, and/or unethical or illegal conduct concerning the Firm?  Yes  No

***If “Yes,” are these employees protected from any possible retaliation when they do report such activities****?*  Yes  No

**34.** Does the Firm have a documented process for handling all employee complaints?  Yes  No

**35.** Do all employees receive a written performance evaluation? Yes  No

***If “Yes,” how often?***

**36.** Does the Firm offer Medical, Dental and 401(k) benefits to each employee? Yes  No

**Part VI: Additional Information**

*Please attach each of the following, if they exist. If they do not exist, please explain under Part VI on the EPL Insurance Supplement (E-1).*

##### Your employee handbook

* Employment application form(s)

##### Equal employment opportunity policy

##### Discrimination and sexual harassment policy

##### Separation agreement form

**Part VII: Signature**

***The below authorized owner or partner declares that the following is understood. After inquiry of all stockholders, partners and employees, I am not currently aware of any employment practices, incident, circumstance, dispute or problem which could reasonably be expected to be the basis of a claim being made against the firm, its predecessors or any partner, officer or employee, by any current or former employee, contract worker, independent contractor, applicant or other third party, that has not been reported to CAMICO. I also am aware that the failure of any Insured to disclose such known facts, employment practices, incident, circumstance, dispute or problem here may entitle CAMICO to void the proposed policy in its entirety if CAMICO establishes that any Insured has misrepresented or concealed any information that is material to the risk and/or that contributed to a claim for which coverage is sought.***

***The undersigned proprietor, authorized partner of the partnership, or authorized stockholder of the corporation represents that the following statements are understood and agreed to by the applicant:***

By signing this application, the undersigned represents that he or she has made inquiries of all Firm members as appropriate and that all Firm members are bound by the representations made on this application, any supplemental application, and any supplemental data and documents provided.

Signing this application or tendering premium does not bind the applicant or the company to issue insurance coverage, but it is agreed that this application shall be the basis of the contract should a policy be produced.

***IMPORTANT: CAMICO intends to rely upon your answers to questions in this application and any attached supplements in reaching its decision to offer coverage and/or to offer coverage excluding any described activities. Inaccurate responses to inquiries may result in a loss of coverage for activities and/or a decision by CAMICO to rescind the entire policy. Your signature below acknowledges your understanding of this notice.***

**FRAUD WARNING – NEW YORK RESIDENTS**

NOTICE TO 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.

**Name: (Please Print)**       **Signature: ­­­­­­­­­­­­­­­­**  **Date:**       **Position/Title:**       **Applicant/Firm:**

**Thank you for applying for CAMICO coverage. Please send completed application and appropriate supplemental forms to:**

**Sales Department Call: 1.800.652.1772**

**CAMICO Mutual Insurance Company E-mail: inquiry@camico.com**

**PO Box 1696 Web:** [**www.camico.com**](http://www.camico.com)

**Albany, NY 12201-9906 Fax: 1.800.227.2090**

**NOTICE TO POLICYHOLDER – NEW YORK**

***DISCLOSURE NOTICE PURSUANT TO NEW YORK INSURANCE DEPARTMENT REGULATION 107***

**100% *CLAIMS EXPENSE* OFFSET LIMIT OF LIABILITY AND DEDUCTIBLE**

This signed statement must be attached to, and made a part of, your policy.

Your signature on this statement acknowledges that you are aware, understand and agree that:

1. The Limit of Liability provided by this Policy shall be reduced and may be completely exhausted by *Claim Expenses*; and
2. To the extent that the Limit of Liability is exceeded, the *Named Insured* shall be liable for *Claim Expenses* and for the amount of any judgment or settlement; and
3. *Claim Expenses* that are incurred shall be applied first against the Deductible up to 100% of the amountof the Deductible, and then against the applicable Limit of Liability.

*Named Insured*:

By:

Signature of a Principal or Partner

Name/Title:

Print Name and Title

Date: