



SCOTTSDALE INSURANCE COMPANY®

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

Employment Practices Liability Insurance

This application is for a Claims Made policy.

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

GENERAL INFORMATION

1. Name (This is the name of the firm or the parent/holding company):

2. Address:

City: State: Zip Code:

Additional Locations:

3. Business Type: Corporation Partnership Professional Corporation
Sole Proprietorship Other (specify):

4. a. Date Business Established:

b. Describe Nature of Business:

5. a. Are you in bankruptcy or contemplating any form of bankruptcy? Yes No

b. Do you have positive net worth and sufficient working capital? Yes No

6. Complete the following for any subsidiaries more than 50% owned by you that you want covered. Include these employees in Question #11:

Table with 6 columns: Name, Location, Nature of Business, % of Interest, Date Acquired/Established, # of Employees

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

a. Merged or acquired another entity in the last 24 months? Yes No

b. Any plans to merge or acquire another entity within next 12 months? Yes No

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

Table with 5 columns: Name, Location, Nature of Business, % of Interest, Date Acquired/Established

- 1) With respect to these mergers/acquisitions, did you terminate any employees or officers? Yes No
 If yes, how many employees? _____ Officers? _____
- 2) With respect to these mergers/acquisitions, do you plan to terminate any employees or officers within the next 12 months? Yes No
 If yes, how many employees? _____ Officers? _____
8. **Any plans to close an office or lay off 5% or more of employees within the next 12 months?** Yes No
 If yes, please explain: _____
 Do you have a formal "reduction in force" policy? Yes No
 If yes, provide copy.
 If no, how will the closings be handled? _____

EMPLOYEE INFORMATION

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

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

*Defined as employees working less than 32 hours per week/1600 per year.
 **All Leased employees are to be shown under "(L)" category, whether Part-Time or Temporary.

10. **Current number of Independent Contractors:** _____
Please note that no coverage is afforded for Independent Contractors unless specifically requested and endorsed to the policy. Do you want coverage for Independent Contractors?.... Yes No
 If yes: a. Do the Independent Contractors work only for you? Yes No
 b. Are Independent Contractors under the same direction and control as employees? Yes No
11. **How many employees from Question 9 are international employees working on foreign lands?** _____
 (List countries where international employees are located and indicate the number of employees in each country): _____
12. **Current number of employees that are union versus non-union:** Union: _____ Non-union: _____
13. **Breakdown of current Full-Time employees by their total cash compensation (salary + bonus):**

Salary Ranges	Number of Employees	Percent of Total
\$100,000 per year or less		
Over \$100,000 per year		

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

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

EMPLOYMENT INFORMATION

15. Do you have a Personnel/Human Resource Department? Yes No

(If no, answer 15.b.)

a. If yes, number of staff: _____ To whom does Personnel/HR report? _____

b. If no, explain who is responsible for this function, the person's qualifications and how long in position: _____

c. Do all managers and supervisory personnel receive training on how to conduct proper:

Interviews?..... Yes No

Terminations?..... Yes No

Performance Reviews?..... Yes No

Exit Interviews?..... Yes No

Progressive Discipline?..... Yes No

d. Do all managers and supervisory personnel receive training on the company's policies and procedures for:

Discrimination?..... Yes No

Sexual Harassment?..... Yes No

Termination?..... Yes No

Handling Complaints?..... Yes No

16. Do you have an employee handbook? Yes No

a. Do you distribute policy statements on or does your handbook contain:

(1) Sexual Harassment policy?..... Yes No

(2) Anti Discrimination policy? (EEOC)..... Yes No

(3) Employment-at-Will Statement?..... Yes No

(4) A Disclaimer stating the Handbook is not a contract?..... Yes No

b. Does every employee receive a copy?..... Yes No

c. Is your Sexual Harassment policy distributed annually to all employees?..... Yes No

d. Do you get written acknowledgment that employees received the handbook or policy statements at time of hire and when redistributed after or after changes are made?..... Yes No

e. Is the handbook reviewed at least every three years?..... Yes No

f. What is the date of the last update? _____

g. Has it been reviewed by a labor relation's attorney?..... Yes No

17. If no handbook, how does the company relay its employment policies and procedures to employees? _____

18. Do you have a formal, standardized employment application? Yes No

a. Has it been reviewed by a labor relation's attorney?..... Yes No

b. Does it have an Employment-at-Will statement?..... Yes No

c. Does it have an Equal Opportunity Employer statement?..... Yes No

If no application is used, how do you screen/consider new employees? _____

19. Do you use any psychological tests to screen applicants, to promote employees or for the purposes of continuing employment?..... Yes No

If yes, describe type of test and how the test is administered, i.e., to all employees or segments: _____

Has the test been validated? Yes No

20. Do you require drug testing or physical exams of employees? Yes No

If yes, under what circumstances? _____

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

21. Do you use any other tests to screen applicants? Yes No

If yes, describe: _____

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

23. Have you reviewed your employment policies, practices and procedures to determine if you are in compliance with the Americans With Disabilities Act?..... Yes No Not Applicable

a. Have you or do you plan to implement changes to comply with the Act? Yes No Not Applicable

Please explain: _____

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

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

If no, do you have job descriptions for all administrative, professional, semi-professional and or management/supervisor positions? Yes No

25. Do you provide a written performance evaluation for all employees?..... Yes No

If yes, how often? _____

If no, why not? _____

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

27. Do you have an established internal dispute resolution program?..... Yes No

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

29. Do you have a written procedure for handling complaints?..... Yes No

30. Do you require counsel from a human resource professional or qualified labor relation's attorney prior to terminating an employee?..... Yes No

31. Do you conduct exit interviews?..... Yes No

32. Do you offer:

a. A severance package?..... Yes No

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

33. Do you provide a sexual harassment statement to your employees as follows:

a. Statement clearly states who an incident should be reported to (including an alternate if needed)? Yes No

b. Statement advising them that they need to advise management if they are being harassed in any fashion? Yes No

c. If 33.a. or 33.b. is answered No, do you agree to implement such a procedure(s) within sixty (60) days of binding coverage? Yes No

CLAIMS HISTORY

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

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

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

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

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

National Labor Relations Board..... Yes No

Equal Employment Opportunity Commission..... Yes No

Federal Labor Standards Act..... Yes No

Fair Labor Standards Enforcement Act..... Yes No

Title VII of the Civil Rights Act of 1964..... Yes No

Civil Rights Act of 1991..... Yes No

Age Discrimination in Employment Act..... Yes No

Americans With Disabilities Act..... Yes No

U.S. Department of Labor..... Yes No

Any state or local government agency such as the Labor Department or Fair Employment Agency..... Yes No

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

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

INSURANCE INFORMATION

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

If yes, please provide:

Policy Period	Retro Date	Insurer	Limits	SIR/Deductible	Coinsurance	Premium

38. Limits of Liability requested:

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

39. Deductible requested:

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

SIGNATURE SECTION AND OTHER INFORMATION

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

NEW YORK—WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.

THE FIRM UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY BE ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY. THE FIRM ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION OR OTHERWISE.

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

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