



**EMPLOYMENT PRACTICES  
 LIABILITY INSURANCE  
 APPLICATION**

3001 Philadelphia Pike  
 Claymont, DE 19703-2580  
 Tel: 800-558-8808 • Fax: 302-764-5477  
 Email: sales@rockwoodinsurance.com  
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**THIS APPLICATION IS FOR A CLAIMS-MADE POLICY. PLEASE READ YOUR POLICY CAREFULLY**

*Applicant may qualify for a QUICK QUOTE by completing Section I below. Sections II, III, IV, & V answers will be required prior to binding and are subject to underwriting approval. QUICK QUOTE is not available for accounts with losses in the past 5 years. If there is a loss history, please complete the entire application and submit details in a Claim Supplement.*

**I GENERAL INFORMATION**

- A. Applicant/Named Insured \_\_\_\_\_
- B. Physical Address \_\_\_\_\_  Same as mailing address  
 (P.O. Box is not an applicable address)  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_
- C. Web Address \_\_\_\_\_
- D. Primary Contact: Email Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_
- E. Description of Operations \_\_\_\_\_
- F. Business is:  Corporation  Individual Proprietor  Partnership  LLC  Other (specify) \_\_\_\_\_
- G. Full time \_\_\_\_\_ Part \_\_\_\_\_ Temporary/ \_\_\_\_\_ Independent \_\_\_\_\_ Volunteer/  
 Employees \_\_\_\_\_ Time \_\_\_\_\_ Seasonal \_\_\_\_\_ Leased \_\_\_\_\_ Contractors \_\_\_\_\_ Interns \_\_\_\_\_
- H. What percentage of employees belong to a Union . . . . . %
- I. List below the Number of Employees in Top 3 States by State: Employees Outside the U.S. \_\_\_\_\_  
 1. State \_\_\_\_\_ Number of Employees \_\_\_\_\_ 2. State \_\_\_\_\_ Number of Employees \_\_\_\_\_ 3. State \_\_\_\_\_ Number of Employees \_\_\_\_\_
- J. Number of Locations: Within U.S. . . . . . Outside the U.S. . . . . .

**II UNDERWRITING INFORMATION**

- A. Year Established . . . . . Number of years under current management . . . . .
- B. Do more than 50% of all employees currently earn more than \$100,000? . . . . .  Yes  No
  - 1. Is the Applicant a Subsidiary of another organization? . . . . .  Yes  No
  - 2. Is the Applicant a franchisee of another organization? . . . . .  Yes  No
  - 3. Name of Parent and/or Franchisor and Location: \_\_\_\_\_
- 4. Does the Applicant want any Subsidiary(s) covered? . . . . .  Yes  No  
 If "Yes," include employees in employee count above and provide:
  - a) Name of Subsidiary(s) \_\_\_\_\_
  - b) Is the Subsidiary(s) at least 50% owned by the Applicant? . . . . .  Yes  No
  - c) Does the Subsidiary(s) fall within the same class of business as the Applicant? . . . . .  Yes  No
- 5. Expiring Policy

Retroactive Date	/	/	Limits \$	Retention \$	Premium \$
Expiration Date	/	/	Carrier:		

### III HUMAN RESOURCES

A. Written Guideline Requirements:

- 1. Does each entity proposed for Insurance have a written Email/Internet Policy currently in place or is willing to implement one? . . . . .  Yes  No
  - 2. Does each entity proposed for insurance have a written Anti-Discrimination and Anti-Harassment Policy? . . . . .  Yes  No
  - 3. Does the company have an employee grievance reporting and resolution process? . . . . .  Yes  No
  - 4. Does the company have a HR Coordinator? . . . . .  Yes  No
- If "No", describe how HR functions are administered. \_\_\_\_\_
- \_\_\_\_\_

- 5. Do all employees receive training in the proper implementation of your human resources policies and procedures? . . . . .  Yes  No
- If "Yes," please provide a description and number of hours each employees is required to take.**
- \_\_\_\_\_

- 6. Do you have a written policy with respects to progressive discipline for Employees. . . . .  Yes  No
- 7. If you have a public website, does it comply with the Web Content Accessibility Guidelines (WCAG) 2.0? . . . . .  Yes  No
- 8. Do you have procedures in place to deal with biometric privacy laws? . . . . .  Yes  No
- NY Applicants Only: Is your organization in compliance with the Gender Expression Non-Discrimination Act? . . . . .  Yes  No
- 9. Is any Family and Medical Leave (FMLA) provided gender-neutral? . . . . .  Yes  No

### IV BUSINESS PRACTICES

- A. 1. Has any entity proposed for insurance closed, sold, merged-with or acquired any company in the past 12 months or anticipate doing so in the next 12 months? . . . . .  Yes  No
  - 2. Has any entity proposed for insurance downsized, laid off, or reduced staff in the past 12 months or anticipate doing so in the next 12 months? . . . . .  Yes  No
- If "Yes," please complete the following three questions.**
- a) What percentage of the workforce was/will be affected? . . . . . \_\_\_\_\_ %
  - b) How and why were the individuals selected? Provide details on separate sheet of paper.
  - c) What will be offered? (Check all that apply):  
 Re-location arrangements     Re-training     Severance package     Out-placement

- B. Has any Policy for Employment Practices Liability Insurance ever been canceled or non-renewed by the carrier? . . . . .  Yes  No

- C. Do you own any other entities? . . . . .  Yes  No
- If "Yes", please provide details on Supplemental Application.

### V CLAIMS HISTORY

- A. Within the last 5 years, has any employment related, or third party discrimination, or third party harassment inquiry, complaint, notice of hearing, claim, or suit been made against any entity proposed for insurance or any person proposed for Insurance in the capacity of either Director, Officer, Member (if an LLC), or Employee of any entity proposed for insurance. . . . .  Yes  No **If "Yes," complete Claim Supplemental for each claim.**
  - B. Is any person proposed for this Insurance aware of any fact, circumstance, or situation which may result in an employment claim, or third party discrimination, or third party harassment claim against any entity proposed for Insurance or any of its Directors, Officers, Members (if LLC), or Employees? . . . . .  Yes  No
- If "Yes," complete Claim Supplemental for each claim.**

**VI OPTIONAL COVERAGES**

- A. Are you looking for Wage and Hour coverage? .....  Yes  No  
*If "Yes", please complete Wage and Hour supplemental application.*
- B. Are you looking for Third Party coverage? .....  Yes  No
- C. Are you looking for Defense Outside the Limits of Liability Coverage? .....  Yes  No

**VII ADDITIONAL APPLICANT INFORMATION**

Applicant's  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## FRAUD STATEMENTS Continued . . .

termination of this policy. The Insured may purchase for an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.

**North Dakota Fraud Statement:** Notice to North Dakota applicants-Any person who knowingly and with the intent to defraud an 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.

**Ohio Fraud Statement:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. Ohio Representation Statement: By acceptance of this policy, the Insured agrees the statements in the application (new or renewal) submitted to the company are true and correct. It is understood and agreed that the statements made in the insurance application are incorporated into, and shall form part of, this policy.

THE INSURED UNDERSTANDS AND AGREES THAT ANY MATERIAL MISREPRESENTATION OR OMISSION ON THIS APPLICATION WILL ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY THE RIGHT TO RESCIND IT..

**Oklahoma Fraud Statement:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of felony.

**Oregon Fraud Statement:** Notice to Oregon applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**Pennsylvania Fraud Statement:** 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.

**Tennessee Fraud Statement:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Utah Notice:** I understand that Punitive Damages are not insurable in the state of Utah. There will be no coverage afforded for Punitive Damages for any Claim brought in the State of Utah. Any coverage for Punitive Damages will only apply if a Claim is filed in a state which allows punitive or exemplary damages to be insurable. This may apply if a Claim is brought in another state by a subsidiary or additional location(s) of the Named Insured, outside the state of Utah, for which coverage is sought under the same policy.

**Utah Fraud Statement:** Any person, who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Vermont Fraud Statement:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be subject to fines and confinement in prison.

**Virginia Notice:** This Policy is written on a claims-made basis. Please read the policy carefully to understand your coverage. You have an option to purchase a separate limit of liability for the extended reporting period. If you do not elect this option, the limit of liability for the extended reporting period shall be part of the and not in addition to limit specified in the declarations. If you have any questions regarding the cost of an extended reporting period, please contact your insurance company or your insurance agent. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidates coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

**Virginia Fraud Statement:** Any person who knowingly and with intent to defraud an insurer, submits an Application for insurance or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Washington Fraud Statement:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Fraud Statement (All Other States):** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Missouri & Rhode Island Disclosure Notice:** I understand and acknowledge that if a \$100,000 or \$250,000 Limit of Liability is chosen or if the Insured's Organization has more than 200 employees, that Defense Costs are a part of the Limit of Liability. This means that Defense Costs will reduce my limits of insurance and may exhaust them completely and should that occur, I shall be liable for any further legal Defense Costs and Damages. Defense Costa is as defined in Section III.

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I also understand that the Limit of Liability for the Extended Reporting Period, if applicable, shall be a part of and not in addition to the limit specified in the Policy Declarations.

If your state requires that we have information regarding you Authorized Retail Agent or Broker, please provide below.

Retail agency name _____	License No. _____
Agent's signature _____ (Required in New Hampshire)	Phone No. (____) _____
Email Address _____	
Agency mailing address _____	
City _____	State _____ Zip _____

The signer of this application acknowledges and understands that the information provided in this Application is material to the Insurer's decision to provide the requested insurance and is relied on by the Insurer in providing such insurance. The signer of this application represents that the information provided in this Application is true and correct in all matters. The signer of this Application further represents that any changes in matter inquired about in this Application occurring prior to the effective date of coverage, which render the information provided herein untrue, incorrect or inaccurate in any way will be reported to the insurer immediately in writing. The Insurer reserves the right to modify or withdraw any quote or binder issued if such changes are material to the insurability or premium charged, based on the Insurer's underwriting guides. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in the Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the Policy.

**New York Fraud Statement:** 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 state value of the claim for each such violation.

**Applicant's Signature** \_\_\_\_\_ **Title** \_\_\_\_\_  
*President, Chairperson of the Board, Managing Member or Executive Director*

**Date** \_\_\_\_\_

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