



Utica National Insurance Group

Insurance that starts with you.

Utica Mutual Insurance Company and its affiliated companies, New Hartford, N.Y. 13413

EMPLOYMENT - RELATED PRACTICES LIABILITY INSURANCE APPLICATION - SHORT FORM

THIS IS AN APPLICATION FOR A CLAIMS-MADE POLICY. SEE NOTICE ON PAGE 3. READ YOUR POLICY CAREFULLY.

THE POLICY INCLUDES DEFENSE COSTS IN ITS LIMITS OF INSURANCE. ANY DEFENSE COSTS PAID UNDER COVERAGE WE PROVIDE WILL REDUCE THE AVAILABLE LIMITS OF INSURANCE UNDER THAT COVERAGE AND MAY EXHAUST THEM COMPLETELY.

Named Insured: _____ Producer: _____
Mailing Address: _____ Producer No: _____
City: _____ State: _____ Zip: _____ Policy Period: _____ to _____

BUSINESS TYPE

a. Individual Corporation Limited Liability Corporation Other _____
b. Franchised Operation Non-franchised Operation
Number of Years in Business: _____ SIC Code: _____
Describe the business operation: _____

COVERAGE INFORMATION

Limits Requested (per claim/aggregate)

\$250,000/\$250,000 \$500,000/\$500,000
 \$1,000,000/\$1,000,000 Other (Refer to Company) _____

Deductible Requested

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

Co-insurance Requested

0% (Basic) 5% (\$25,000 per claim max) 5% (\$50,000 per claim max)
 10% (\$25,000 per claim max) 10% (\$50,000 per claim max)

Prior Coverage Info

Prior Insurance Coverage? Yes No
If yes, was prior coverage cancelled or non-renewed? Yes No
Limit _____ Carrier _____ Retro Date _____

EMPLOYEES

Number of Employees (if more than two locations, also provide this information for the additional locations)

[See NOTES at end of application for definitions of Full-Time, Part-Time Employees.]

See Note 1 Full-Time Employees
See Note 2 Part-Time Employees
Temporary Workers
Leased Workers
* Ind. Contractors

Location 1 (list city, state)			Location 2 (list city, state)		
This Year	Prior Year	2nd Prior	This Year	Prior Year	2nd Prior
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

* If coverage is desired for Ind. Contractors provide full details to underwriter.

Number of employees that are: Salaried _____ Non-Salaried _____
 Number of employees who are union members this year: _____
 Number of employees by salary range: Less than \$30,000 _____
 \$30,000 to \$100,000 _____
 over \$100,000 _____

	This Yr	Prior Yr	2nd Prior
What was your employee turnover rate for the last 3 years? [See Note 3 at end of application.]	_____ %	_____ %	_____ %
What number of terminations were employer-initiated for the last 3 years?	_____	_____	_____

PRIOR YEAR HISTORY

Have you had any office, branch, facility or plant closings, consolidations, layoffs or staff reductions (greater than 10% of the workforce), mergers or acquisitions within the last 12 months? Yes No
 If yes, please describe: _____

Do you anticipate any office, branch, facility or plant closings, consolidations, layoffs or staff reductions (greater than 10% of the workforce), mergers or acquisitions within the net 12 months? Yes No
 If yes, please describe: _____

RISK MANAGEMENT PRACTICES

- Do you use an employment application during your hiring process? If yes, please attach. Yes No
- Do you have a written anti-harassment or discrimination policy? If yes, please attach. Yes No
- Do you have a written equal opportunity statement? If yes, please attach. Yes No
- Do you have a written internal complaint and progressive disciplinary procedure for discrimination and harassment claims? If yes, please attach copies of both. Yes No
- Do you post in places conspicuous to all employees and applicants for employment all notices required by law? Yes No
- Have your employment policies and procedures been reviewed and approved by outside counsel? Yes No

LOSS/CLAIM HISTORY

Has the firm received any employment-related lawsuits, negotiated settlements, grievances, EEOC or other administrative proceedings from any municipal, state or federal regulatory authorities or any other government entities? **If yes, please provide details. If none, write "none" here.** _____

Are you aware of any facts or circumstances, which you reasonably believe, may result in employment-related practices claims being made against the applicant? **If yes, please provide details.**
If none, write "none" here. _____

Loss/Claim History Details (if applicable) (Use separate sheet if more detail necessary).

THE APPLICANT UNDERSTANDS AND AGREES THAT IF ANY FACTS, INCIDENTS, OR CIRCUMSTANCES ARE KNOWN 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.

IMPORTANT CLAIMS-MADE COVERAGE NOTICE

The Coverage Form which provides Employment-Related Practices Liability Coverage applies on a claims-made basis.

The following provides a general description of this coverage and is subject to the terms and provisions of the actual Coverage Form. Terms in quotation marks are defined in the Coverage Form.

- A. The Coverage Form, subject to its terms and conditions, provides full prior acts coverage if no Retroactive Date is entered in the Declarations. If a Retroactive Date is entered in the Declarations, the Coverage Form will not apply to "claims" for "employment-related practices" which took place before the Retroactive Date. The Coverage Form will not apply to "claims" for "employment-related practices" which take place after the expiration of the "policy period."
- B. The Coverage Form will apply to "claims" for "employment-related practices" which took place on or after the Retroactive Date, if any, but before the beginning of the "policy period" **only if** any "claim" is made according to D. below.
- C. The Coverage Form will not apply to any "employment-related practice" for which "claim" is first made after the expiration of the "policy period" or any Automatic or Optional Extended Reporting Period described in the Extended Reporting Period Section of the Coverage Form.
- D. The Coverage Form will apply only to "claims" which are first made:
 - 1. During the "policy period";
 - 2. During the ninety day Automatic Extended Reporting Period described in the Extended Reporting Period Section of the Coverage Form;
 - 3. During the five year Automatic Extended Reporting Period described in the Extended Reporting Period Section of the Coverage Form for "claims" arising out of "employment-related practices" reported, under the policy provisions, no later than ninety days after the end of the "policy period"; or
 - 4. During the 12 month or 36 month Optional Extended Reporting Period described in the Extended Reporting Period Section of the Coverage Form. Such Optional Extended Reporting Period must be requested by the first Named Insured in writing, by the later of sixty days after the date of "termination of coverage," or thirty days after the date of mailing by us of notice to the first Named Insured advising of premiums for and provisions of the Optional Extended Reporting Periods, in order to allow "claims" to be made against the policy coverage after the expiration of an Automatic Extended Reporting Period.
- E. We will send to the first Named Insured shown in the Declarations a written notice, within thirty days after any notice of "termination of coverage," of the premium for and provisions of the Extended Reporting Periods, unless we cancel for nonpayment of premium or fraudulent activities of any insured.
- F. For the first three years of claims-made coverage, premiums will be comparatively lower than for occurrence coverage, and will increase for each renewal of those policies. Claims-made prices will still be somewhat lower than occurrence prices for mature accounts (in their fourth or later years). The purchase of Optional Extended Reporting Periods, as described above, requires additional premium payments.

A review of the Extended Reporting Period provisions in your policy, as summarized above, will underscore the importance of both the Automatic and Optional Extended Reporting Periods.

The applicant understands and agrees this application, original application, and any supplements thereto will be deemed attached to and made part of the policy, whether physically attached or not, and any successive renewals that may be issued, and that the Insurance Company relies on the truth of the statements set forth herein in making a determination to issue any policy.

The applicant represents to the best of his or her knowledge and belief that the statements set forth herein are true and include all material information. The applicant further represents that if the information supplied on this application changes between the date of the application and the inception date of the policy period, the applicant will notify the Insurance Company of such change.

IMPORTANT FRAUD INFORMATION

See attached "Fraud Addendum" for important Fraud Information regarding the completion of this application. By signing this application you certify that you have read such Fraud Information that applies to you. That addendum will be deemed attached to and made part of this application and to any revisions, supplements or other additions to it.

The signing of this application does not bind the applicant to accept any insurance offered, nor does the signing of the application bind the insurance company to issue or renew an insurance policy.

	SIGNATURE	DATE (MM/DD/YY)
APPLICANT'S <i>Proprietor, Partner, or Officer</i>		
APPLICANT'S <i>HR Representative</i>		
AGENT		

NOTES:

Employee Definitions:

- 1. Full-Time: Employees working 32 hours per week/1600 per year or more.
- 2. Part-Time: Employees working less than 32 hours per week/1600 per year.

Turnover Rate:

- 3. Number of Full-Time and Part-Time employees terminating employment (whether initiated by employer or employee) during the year divided by the total at the start of the year (e.g. Total employees at start of year = 100; Number of employees terminating employment during year = 5; $5 \div 100 = 5\%$ Turnover Rate)

IMPORTANT: THIS APPLICATION MUST HAVE FRAUD ADDENDUM FORM 8-A-419 ATTACHED TO IT TO BE CONSIDERED COMPLETE (SEE "IMPORANT FRAUD INFORMATION" SECTION ABOVE).