



Medical Providers Protection for Employment Practices Liability Application

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY THE CHAIRPERSON OR PRESIDENT OF APPLICANT.
THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY – PLEASE READ YOUR POLICY CAREFULLY
Defense Costs shall be applied against the Retention.

1. Name of Organization: _____
 Primary Address: _____
 City: _____ State: _____ Zip: _____
 Website Address: _____ E-mail Address: _____
2. Person to receive all notices on behalf of the Insured: _____
 Title: _____ Email Address: _____
3. Do you have more than one location? Yes No
 If yes, attach a list of all locations, including the address and the number of employees at each site.
4. Nature of Operations: Clinic Medical Office Dental Office Other: _____
 Area of Specialty(ies): _____
5. Number of years in operation: _____ If less than 3 years, provide resumes of the Owners/Principals/Partners/Key management confirming prior experience)
6. Is the Applicant a subsidiary of another Organization? Yes No
 Name of Parent: _____ Location: _____
7. Total number of employees

	Current 12 months	Prior 12 months	Anticipated next 12 months (If operating less than 3 years)
Full Time: (Other than Employed Doctors)	_____	_____	_____
Part Time: (Other than Employed Doctors)	_____	_____	_____
Employed Doctors (Not Principals or Partners)	_____	_____	_____
Temporary/ Seasonal:	_____	_____	_____
Independent Contractors:	_____	_____	_____
Leased	_____	_____	_____
8. How many employees have been involuntarily terminated in the past 12 months? _____ 24 months? _____
9. Has the Organization closed, downsized, laid off, reduced staff, sold, merged or acquired any company in the past 12 months? Yes No
 Does the Organization anticipate doing so in the next 12 months? Yes No
 If yes, please attach details.
10. Percentage of employees (not including employed doctors) with total compensation including salaries, bonuses and commissions over \$75,000 _____%
11. Does the Organization currently carry Employment Practices Liability Insurance? Yes No
 If Yes, provide the following:

Name of Insurer	Limits	Policy Period	Deductible/Retention	Premium	Retroactive date

12. Does the Organization want any subsidiary(s) covered? Yes No
 If yes, provide name(s), nature of operation, number of employees and the percentage of ownership the organization has in the subsidiary(s). _____
13. Has the Organization or any individual proposed for insurance ever denied medical or dental services to any person based, in whole or in part, on race, creed, color, sex, sexual orientation, age, national origin, or disability? Yes No
 If yes, please attach details on a separate sheet.
14. Has the Organization or any individual proposed for Insurance ever denied medical or dental services or have a policy against providing medical or dental services to an individual because of their communicable disease including but not limited to HIV/AIDS? Yes No
 If yes, please attach details on a separate sheet.
15. Within the last 5 years has any complaint, inquiry, notice of a hearing, claim or suit been made against the Organization or any person proposed for Insurance as a result of an alleged Sexual Misconduct to a Patient? Yes No
 If yes, please attach details on a separate sheet.
16. Within the last 5 years has any employment related, or third party discrimination, or third party sexual harassment: inquiry, complaint, notice of hearing, claim or suit been made against the Organization or any person proposed for Insurance in the capacity of either Director, Officer or Employee of the Organization? Yes No
If "Yes," please complete a United States Liability Insurance Group claim supplement for each claim.



- 17. 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 sexual harassment claim against the Organization or any of its Directors, Officers or Employees?
18. Do you have an Email/Internet Policy currently in place? If no, are you willing to implement one? (Sample can be provided by the Company) Please submit a copy of current or newly implemented policy within 21 days after the inception date of this insurance.

MANDATORY WRITTEN EMPLOYMENT POLICIES. Please identify policies applicant has in place:
Anti-Harassment Policy
Anti-Discrimination Policy
Third Party Discrimination Policy

Please forward copies of the policies identified above along with this signed and dated application. If you do not have these written policies in place, the Company will provide you with sample policies at the time of binding this insurance.

- As a condition precedent to issuance of the Policy for Insurance, the Applicant agrees:
1) to implement and distribute to each employee the Mandatory Anti-Harassment and Anti-Discrimination Policies which are currently not in place as soon as possible, but no later than 21 days after the inception date of this insurance.
2) to adopt and distribute to each employee all changes required by the Company to the Applicant's Written Policies, as soon as possible, but no later than 21 days after receipt of notice of the changes required by the Company.

Recommended Written Employment Policies. Please identify policies Applicant has in place:
Employment Application
Employee Handbook
Contains Employment-At-Will Statement?
Contains statement that Handbook is not a contract of employment?

Fraud Statement: Any person who knowingly and with the 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 may subject such person to criminal and/or civil penalties and other sanctions.

Applicant's Warranty Statement: The undersigned represents to the best of his/her knowledge and belief the particulars and statements set forth are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Virginia Notice: 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 be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue

Minnesota Notice: The clause "and/or authorization or agreement to bind the insurance" is replaced with "authorization or agreement to bind the insurance may be withdrawn or modified based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with the minimum of 10 days notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for non payment of premium."

Applicant's Signature: (Owner, Principal, or Partner) Date:

Broker's Signature: Date:

Address:

Some states require that we have the Name and Address of your (Insured's) Authorized Agent or Broker.

Name of Authorized Agent or Broker:

Address:

Mail Completed Application Through Local Agent or Broker to: