



Medical Providers Protection for Employment Practices Liability Renewal 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. Total number of employees
 Full Time: (Other than Employed Doctors) _____
 Part Time: (Other than Employed Doctors) _____
 Employed Doctors (Not Principals or Partners) _____
 Temporary/ Seasonal: _____
 Independent Contractors: _____
 Leased _____
3. Has the Insured opened any new locations in the past 12 months? Yes No
 If yes, please provide the address, number of employees at the new location(s) and the area of specialty(ies) being conducted at the new location(s).

4. Has there been in there been in the past 12 months or do you anticipate in the next 12 months a downsizing, layoff or office closing? Yes No
 If yes, please provide a completed Employment Practices Liability Downsizing, Layoff, Facility Closing Addendum.
5. Has the Insured been involved in a merger or acquisition in the past 12 months or is a merger, acquisition or sale anticipated in the next 12 months? Yes No
 If yes, please provide a completed Employment Practices Liability Merger, Acquisition or Formation of a Subsidiary Addendum.

Signature: _____ Name: _____
(Owner, Principal, or Partner)

Title: _____ Date: _____