Standard Program

Employment Practices Liability Insurance
Houston Casualty Company

HCC

Renewal Application

Section 1. General Information

Please type or print clearly

Name of Applicant Organization:			
Mailing Address:	**City**	**State**	**Zip Code**
HR Contact Name:	**Telephone**	**Fax**	
Email Address:			
Applicant is a (check one) ◇ Corporation ◇ Partnership ◇ LLC ◇ Individual ◇ Other_____			
Indicate Primary SIC Code:	Nature of Business:		
How long has your organization been in business? years			

Indicate your organization's annual receipts and payroll for the following financial years:

	Receipts	Payroll
(1) Last Financial Year	$	$
(2) Current Financial Year	$	$
(3) Next Financial Year	$	$

Current HCC Policy No:	Expiration Date:

Section 2. Corporate History/ Plan **(provide details in the Remarks Section for any Yes answers)**

1. Has your organization acquired any other organizations within the past two (2) years?	Yes_____	No_____
a) - If Yes, were any of the employees or officers of the acquired organization terminated?	Yes_____	No_____
b) - If Yes, do you plan in the next eighteen (18) months to terminate any of the employees or officers of the acquired organization?	Yes_____	No_____
2. Does your organization anticipate any of the following in the next twelve (12) months? Selling, closing, consolidating or spinning-off any plants, offices, subsidiaries or divisions?	Yes_____	No_____
3. Down-sizing, right-sizing, layoffs or any other reduction in number of employees?	Yes_____	No_____
4. Acquiring or merging with any other organization?	Yes_____	No_____
5. Creation of any new business, subsidiary, division, or location?	Yes_____	No_____
6. Increase in the number of employees by more than 20%?	Yes_____	No_____
7. Have you materially changed any of your HR policies and procedures?	Yes_____	No_____
-If Yes, please describe in Remarks section or provide a copy of the change.		

Section 3. Employees

Indicate the total number of workers currently on your payroll below:	
Type of Individual **(Please do not include independent contractors or leased workers. See below.)**	**No.**
Full-time, regular and temporary persons working a standard workweek	
Part-time, regular and temporary persons working a standard workweek	
Interns	
Seasonal Employees	
Volunteers	
Total	
Of the total number of workers, indicate the number who are union members :	

Please provide a breakdown by state of the number of workers for each category					
State	**Full-time**	**Part-time**	**Interns**	**Seasonal**	**Volunteers**

1. Does your organization use leased workers?	Yes_____	No_____
2. If yes, would you like to cover them under this policy?	Yes_____	No_____
3. If yes, indicate the total number of leased workers to be covered	Total:	
4. Does your organization use independent contractors?	Yes_____	No_____
5. If yes, would you like to cover them under this policy?	Yes_____	No_____
6. If yes, indicate the total number of independent contractors to be covered:	Total:	
Please attach a copy of your employee leasing agreement and or independent contractor agreement		

Of the total number of employees indicated above, indicate how many are in each of the following categories. (Do not include leased workers and independent contractors)	
Salary and bonus between $50,000 and $100,000	
Salary and bonus between $100,000 and $250,000	
Salary and bonus in excess of $250,000	

What is your organization's annual employee turnover for each of the last three (3) years: **(Indicate Highest Number of Employees employed at any one time during the year)**			
Years	20_____	20_____	20_____
Number of Employees			
Involuntary Termination			
Voluntary Termination (non-retirement)			
Retired			

Section 4. Important Notices

1. If the inception date of the policy period is more than thirty (30) days after the date of this application, a signed declaration that statements and information provided in this application have not changed or a new signed and dated application will be required.

2. Employee Handbook, written policy and procedures, and employment application should be available upon request.

3. If you are signing this application, note the following:

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON SUBMITS AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILT OF A CRIME, AND MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES AND DENIAL OF INSURANCE BENEFITS.

Section 5. Applicant's Representations and Signature

1. The Applicant represents to the best of its knowledge and belief that the statements set forth herein are true and complete.

2. 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 immediately notify the Insurer of such change, and the Insurer may modify or withdraw any outstanding quotation.

3. Signing of this Application does not bind the Insurer to offer nor the Applicant to accept insurance, but it is agreed that this Application shall be the basis of the insurance and will be attached to and made part of the policy should a policy be issued.

Applicant's Authorized Signature of a Principal, Partner or Officer.

Printed Name:_____ Title:_____

Signature:_____ Date:_____

Producing Broker:_____ License No.:_____

THIS APPLICATION MUST BE SUBMITTED TO:

Professional Indemnity Insurance Agency, Inc. (PIA)
50 California Street, Ste. 940, San Francisco, CA 94111
Telephone: 415-277-2475 Fax: 415-288-0771

Section 6. REMARKS (Use a separate sheet(s) of paper if necessary)

Third Party Discrimination
& Sexual Harassment Coverage
Employment Practices Liability Insurance
U.S. Specialty Insurance Company

Supplemental Application

INSTRUCTIONS:
This form is to be completed if you are seeking to add Third Party Discrimination and Sexual Harassment Coverage to your Employment Practices Liability Policy. This form must be dated and signed by the same individual who signs the application.

Please type or print clearly

Name of Applicant Organization:

1. Do you have written procedures for handling complaints of discrimination and sexual harassment from a "person" other than an "employee"?	Yes _____	No _____
a. If Yes, are all complaints recorded?	Yes _____	No _____
2. Are your facilities designed to accommodate the disabled in compliance with the Americans with Disabilities Act (ADA) law?	Yes _____	No _____
3. If Yes, do you anticipate that your facilities will be in compliance with the ADA law for the next twelve (12) months?	Yes _____	No _____
If No, to either question, please provide an explanation on a separate sheet.		
4. Do you provide training to your employees regarding discrimination and sexual or non-sexual harassment of a person other than an employee?	Yes _____	No _____
5. If Yes, is the training part of a formalized course?	Yes _____	No _____
6. Is training compulsory?	Yes _____	No _____
If Yes, please provide details on a separate sheet of the controls that you have implemented, clearly stating whether or not they will continue to be used in the future.		
7. Have you received any complaints alleging discrimination and/or sexual or non-sexual harassment from a person other than an employee in the past five (5) years?	Yes _____	No _____
8. If yes, provide the total number of complaints received. _____		
Please provide details on a separate sheet including any amounts paid or reserved.		

APPLICABLE TO NEW YORK
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.

I represent after full investigation and inquiry that the statements set forth are true and complete. I understand the information on this form will become a part of my organization's Employment Practices Liability Application and is subject to the same representations and conditions.	
Applicant's Signature	**Date**

General Statement: Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and [NY: substantial] civil penalties. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN, and VA, insurance benefits may also be denied),

APPLICABLE IN COLORADO:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN THE DISTRICT OF COLUMBIA
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORIDA
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

APPLICALBE IN HAWAII
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN KANSAS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT
Any person who knowingly and with intent to defraud any insurance company or another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

APPLICABLE IN MINNESOTA
Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN OHIO
Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA
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 a felony.

APPLICABLE IN WASHINGTON
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.

Employment Practices Liability Insurance

Houston Casualty Companies/ U.S. Specialty Insurance Company

Wage and Hour Coverage Supplemental Form

WAGE & HOUR SUPPLEMENTAL APPLICATION

Eligibility is subject to completion of the Wage and Hour Supplemental Application and underwriter approval. No backdating allowed for this coverage. Coverage must be elected at time of binding.

1. In the past five (5) years has any current or former employee made or threatened a claim for any violation of wage and hour laws, including but not limited to, claims related to meal periods, rest periods or unpaid overtime? If yes, please describe the outcome and how you have changed your practice to prevent claims (attach explanation if needed).	Yes ☐	No ☐
Question 2 does NOT apply to current HCC renewals that have Wage & Hour coverage		
2. Does any manager, supervisor, shareholder, partner or owner within your organization have knowledge of a potential violation of any wage and hour law that could result in a claim for any violation of wage and hour laws, including but not limited to, claims related to meal periods, rest periods or unpaid overtime?	Yes ☐	No ☐
3. In the last 3 years, has any insured received from the Department of Labor or similar federal, state or local agency notice of an audit or other regulatory or administrative investigation related to compliance with or violation of any federal, state or local wage and hour laws?	Yes ☐	No ☐
4. Are all your full time employees allowed to take a meal period of at least 30 minutes during which they are relieved of all duties?	Yes ☐	No ☐
Questions 5-7 apply only to employers with employees located in CALIFORNIA:		
5. Do any of your employees take on-duty meal periods?	Yes ☐	No ☐
6. Are all employees allowed to take a rest period of 10 minutes or more in the middle of each 4 hour work period?	Yes ☐	No ☐
7. Do all salaried employees receive a salary of at least $640 per week (ie; two times the minimum wage) which is not subject to reduction based upon the number of hours they work?	Yes ☐	No ☐
Question 8 applies only to employers with employees located in NEW YORK:		
8. Do all salaried employees receive a salary of at least $600 per week that is not subject to reduction based on the number of hours they work?	Yes ☐	No ☐
Question 9 applies only to employers with employees located in NEW JERSEY:		
9. Do all salaried employees receive a salary of at least $455 per week that is not subject to reduction based on the number of hours they work?	Yes ☐	No ☐

I represent after full investigation and inquiry that the statements set forth are true and complete. I understand the information on this form will become a part of my organization's Employment Practices Liability Application and is subject to the same representations and conditions.

Applicant's Signature:		Date: