Argonaut Insurance Company

EMPLOYMENT PRACTICES LIABILITY INSURANCE

This is an application for Claims Made and Reported Coverage.
Coverage may have defense costs within the limits.

1. Applicant Name **Toddco**
2. Address **702 Rose Ave**
3. City **Venice** State **CA** County Zip Code **90291**
4. Telephone and Fax / E-Mail

   Years in operation **32**
5. Current Number of employees: full-time: **25** part-time: **0** temporary: **0** volunteers **0** leased: **0**
6. Description of business operations **Landscaping**

* Please note that third party coverage is not available for healthcare providers, bars, taverns, or other entities that derive more than 25% of revenue from alcohol sales. Third party coverage may also be restricted based on the risk profile of the applicant.

7. List all locations by state and include approximate number of employees at each location. (Attach additional sheets if needed.)

   California 25
8. Provide the percentage of employees for the prior 12 months who left:
   a. Voluntarily (resigned or quit): **>10% and <=20%**
   b. Involuntarily (terminated or laid-off): **<=5%**
9. Indicate the percentage of employees whose salary (including commissions and bonuses) is:

   Greater than $50,000 Greater than $100,000
10. Does the Applicant have the following written policies:
    A. Anti-Discrimination/EEO **Yes**
    B. Harassment **Yes**
    C. Employment At-Will **Yes**
    D. Employee Leave **Yes**
    E. Employee Acknowledgement Form **No**
    F. Handling complaints from third parties for issues involving harassment, discrimination or retaliation **No**
11. Does the Applicant use any tests to screen applicants either for hire or promotion? **No** If "Yes," please provide details. (Attach additional sheets if needed)

    _____
12. Have you had or do you anticipate any facility closing or layoffs?: **No**
13. Current limit of liability, retroactive date, and deductible

    / **at inception** /
14. Requested limit and deductible /

PAST HISTORY

15. Please furnish a list and description of all employment related and third party losses, claims, demand letters, litigation or administrative matters filed with the EEOC or other administrative agency in the past three (3) years. On a separate sheet, please provide: a.) initial date of the matter; b.) a complete description of the matter,

including the type of matter (e.g. harassment, race, sex, age, disability or other); and c.) the amount paid or reserved (including expenses). (Attach additional sheets if needed.) If there were no losses**, please state NONE.**

None

16. Please provide a description of any facts or circumstances, which may result in employment practices claims being made against the applicant, entity or its agents. If none, state **NONE. None** (Attach additional sheets if needed.)

_____

17. THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT TO THE BEST OF HER/HIS KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY IN CONNECTION WITH THIS APPLICATION, THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS ACCURATE AND COMPLETE. THE SUBMISSION OF THIS APPLICATION DOES NOT BIND THE INSURER TO PROVIDE, OR THE APPLICANT TO PURCHASE, THE INSURANCE. THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE INSURER, AND ALONG WITH THE APPLICATION, IS CONSIDERED PHYSICALLY ATTACHED TO THE POLICY AND WILL BECOME A PART OF THE POLICY. THE INSURER WILL HAVE RELIED UPON THIS APPLICATION AND ANY ATTACHMENTS IN ISSUING ANY POLICY. IF THE INFORMATION IN THIS APPLICATION CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE INSURER, AND THE INSURER MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION.

THE UNDESIGNED DECLARES THAT THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE UNDERSTANDS THAT:

(a) THE POLICY SHALL APPLY ONLY TO COVERED"CLAIMS" MADE AND REPORTED TO THE INSURER DURING THE "POLICY PERIOD" OR TO "CLAIMS" MADE TO THE INSURER DURING ANY APPLICABLE EXTENDED REPORTING PERIOD;

(b) THE INSURER IS NOT OBLIGATED TO PAY ANY LOSS OR DEFEND ANY CLAIM AFTER THE LIMIT OF LIABILITY HAS BEEN EXHAUSTED BY PAYMENT OF LOSS.

GENERAL FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 subject the person to criminal and [NY: substantial] civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, insurance benefits may also be denied.

	APPLICANT'S SIGNATURE		DATE (MM/DD/YY)	

SIGNED:_____ **DATE:**_____

APPLICANT'S AUTHORIZED SIGNATURE OF A PRINCIPLE, PARTNER OR OFFICER

_____

Print Name/Title