

Berkley Insurance Company

Executive Liability Insurance Renewal Proposal Form for Employment Practices Liability

CLAIMS MADE WARNING FOR APPLICATION: This Proposal Form is for a Claims Made and Reported Policy, relating to claims made against the Insureds during the Policy Period or any Extended Reporting Period that may apply.

➤ Provide details to all "Yes" answers, when applicable, by attachment whether or not prior coverage was in place.

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the **Policy**. This Proposal Form is to be completed with respect to the entire Insured Entity. **Insured Entity** as used herein is defined to include the **Named Insured** and any **Subsidiaries**.

Name of **Named Insured** _____

Primary Location Street Address _____ Suite _____

City _____ County _____ State _____ Zip Code _____

Website Address (if applicable) _____ Federal Employer Identification Number (FEIN) _____

Name and title of officer designated as agent of all **Insureds** to receive any and all notices from the **Insurer**, including but not limited to complimentary Risk Management Services _____

E-mail Address _____ Telephone Number _____ Fax Number _____

The contact information provided will be used for internal purposes and will not be sold to any third party.

The mailing address is the same as the primary location. If not, provide mailing address:

Mailing Street Address _____ Suite _____

City _____ State _____ Zip Code _____

Limit Requested

Terms Requested: _____ Limit: \$ _____ Deductible: \$ _____

Current Insurance Information

1. Provide the following information regarding the **Insured Entity's** most recent insurance policies. If "None", so state.

Type of Coverage	Carrier	Expiration Date	Limit	Deductible	Premium
Directors and Officers Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Employment Practices Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Fiduciary Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Crime / Employee Dishonesty: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Kidnap / Ransom Coverage: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Employed Lawyers Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____

2. Within the last 3 years, has any **Claim** been made or has notice been given under any of the above listed policies or similar insurance? Yes No

3. Within the last 3 years, has any of the above listed policies or similar insurance for the **Insured Entity** been cancelled or non-renewed? (NOT APPLICABLE IN MISSOURI) Yes No

General Information

4. (a) Form of organization: Cooperative Corporation Joint Venture*

Limited Liability Corporation Nonprofit Partnership*

Sole Proprietorship / Individual Other: _____

*If a Joint Venture or Partnership, provide participation or ownership structure details by attachment.

(b) Type of organization: Manufacturing / Production Public Administration Retail Trade

Service Industry Web Based Wholesale Distributing

5. The **Named Insured** has been in continuous operation since: _____

6. (a) What is the **Insured Entity's** Primary Standard Industrial Classification ("SIC") Code? _____

(b) Describe the **Insured Entity's** nature of operations: _____

(c) Does the **Insured Entity** have a membership in any industry/trade association(s)? Yes No

If "Yes", provide the association name(s): _____

7. Is the **Named Insured** or any **Subsidiary** publicly held or a public reporting company under the Securities Exchange Act of 1934? Yes No
8. Provide the following financial information with respect to the **Insured Entity**:
 Assets (000): \$ _____ Annual Revenues (000): \$ _____ Period Ending: ____ / ____ / ____
 Equity (000): \$ _____ Net Income / Loss (000): \$ _____
9. Is the **Insured Entity** currently in bankruptcy? Yes No
10. Within the next 12 months:
 (a) is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code? Yes No
 (b) does the **Insured Entity** anticipate any plant, facility, branch or office closings, or layoffs? Yes No
11. Within the last 18 months:
 (a) has there been any change (resignations, departures, retirements, etc.) in the position of the Chairman of the Board, President, Chief Executive Officer, Chief Financial Officer or Managing Partner (or equivalent position)? Yes No
 (b) has the **Insured Entity** conducted any plant, facility, branch or office closings, or layoffs? Yes No

IF "YES" TO ANY PART OF QUESTIONS 10. OR 11. PROVIDE DETAILS BY ATTACHMENT.

Subsidiary Information

12. Provide the following information on all **Subsidiaries** of the **Insured Entity**. If "None", so state. None
- | <u>Subsidiary Name</u> | <u>Nature of Business</u> | <u>Percent*
Owned by
Insured Entity</u> | <u>Date
Created or
Acquired</u> | <u>Domestic /
Foreign</u> | <u>Nonprofit</u> |
|------------------------|---------------------------|-------------------------------------------------|-----------------------------------------|-------------------------------|----------------------------------------------------------|
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

*If **Subsidiary** is less than 100 percent owned, provide details to all other owners, by attachment.

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED HERE OR BY ATTACHMENT.

Loss History Information

13. During the last 5 years, has any **Insured**, including any **Subsidiary**, received any written demands for monetary or non-monetary relief, been involved in, or had any knowledge of any civil or criminal action, administrative or arbitration, regulatory investigation or proceeding, including both domestic or foreign equivalents, involving:
- (a) any current or former employee or third party alleging discrimination, harassment, wrongful discharge and/or any wrongful employment act? Yes No
 - (b) the Equal Employment Opportunity Commission or any similar state or local agency? Yes No
 - (c) the U.S. Department of Labor or any similar state or local agency, alleging violations of any wage and hour law, including but not limited to, the Fair Labor Standards Act? Yes No
 - (d) any government agency such as the Labor Department or fair employment agency? Yes No
 - (e) the U.S. Immigration and Customs Enforcement Agency? Yes No
 - (f) the National Labor Relations Board? Yes No
 - (g) any investigation by the Internal Revenue Service, Department of Labor, Pension Benefit Guarantee Corporation, or any other local, state or federal agency? Yes No
 - (h) any intellectual property disputes, including Copyright, Patent, or Trademark Laws? Yes No
 - (i) any Security Law or Regulation? Yes No
 - (j) any Anti-Trust or Fair Trade Law? Yes No
 - (k) the Foreign Corrupt Practices Act? Yes No
 - (l) the Office of Federal Contract Compliance Programs? Yes No
14. During the last 5 years, has any **Insured**, including any **Subsidiary**, been involved in any lawsuit not disclosed above? Yes No

IF "YES" TO ANY PART OF QUESTIONS 13. OR 14. PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION BY ATTACHMENT:

(a) Date Claim first made	(b) Claimant's Name	(c) Allegation	(d) Current Status
(e) Demand Amount	(f) Settlement (Indemnity) or Reserve Amount	(g) Attorney's fees	(h) Remedial Action Taken

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTIONS 13. OR 14.

Employment Practices Liability Information

15. (a) Number of **Employees**: Do not include Leased Employees or Independent Contractors in numbers below.

	<u>Full Time</u>	<u>Part Time</u>	<u>Seasonal and/or Temporary</u>	<u>Volunteers and/or Interns</u>	<u>Annual Turnover Rate</u>
Current Year:					
Last Year:					

(b) How many Leased Employees does the **Insured Entity** employ annually? _____

(c) How many Independent Contractors does the **Insured Entity** utilize annually? _____

16. What percentage of the **Insured Entity's Employees** currently earn more than \$100,000? _____ %

17. Provide the following information on all plants, facilities, branches or offices of the **Insured Entity**. If "None", so state. None

<u>Location</u>	<u>Nature of Business</u>	<u>Number of Employees</u>	<u>Domestic / Foreign</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

18. Does the **Insured Entity** currently employ a full time Human Resources professional? Yes No

19. Indicate which formal written policies and procedures have been implemented. If "None", so state. None

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Employee Handbook / Manual
<input type="checkbox"/> Adherence to Employment "at-will" relationship with all Employees
<input type="checkbox"/> Anti-Discrimination Equal Employment Opportunity Policy
<input type="checkbox"/> Anti-Harassment Policy, including Sexual Harassment
<input type="checkbox"/> Social Media Policy | <input type="checkbox"/> I-9 Verification
<input type="checkbox"/> Family Medical Leave Act
<input type="checkbox"/> California Employers Only
<input type="checkbox"/> California Family Rights Act |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

20. Does the **Insured Entity** (details to "Yes" or "No" answers are not required by attachment):

- | | |
|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| (a) utilize employment applications for all prospective Employees ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) require the Human Resource Department to review and approve each proposed Employee termination? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) have outside employment counsel review each proposed Employee termination? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (d) maintain a written policy prohibiting Sexual Harassment and distribute that policy to all Employees ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (e) conduct mandatory periodic Employee education regarding prohibited forms of harassment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (f) periodically have its employment policies and procedures reviewed by outside employment counsel? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (g) periodically have its employment policies and procedures distributed to all Employees? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (h) have a written procedure for notification and handling of employment related grievances, disputes, notifications, or claims? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Producer Information

Submitted by (Agency Name) _____ Dated _____

Agent's Name (Individual's Name) _____ Agent's License Number _____

Please Read Carefully

The undersigned, acting on behalf of all proposed **Insureds**, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each **Insured** proposed for this insurance to facilitate the proper and accurate completion of this Proposal Form.

The undersigned agree that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and are the basis of the insurance contract. The undersigned further agree that the Proposal Form and any material submitted herewith shall be considered attached to and a part of the **Policy**. Any material submitted with the Proposal Form shall be maintained on file (either electronically or paper) with the **Insurer** and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the **Policy** inception date, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any **Policy**, if issued, will be in reliance upon the truth of such representations, provided, however, with respect to such statements and representations, no knowledge or information possessed by any **Insured Person** shall be imputed to any other **Insured Person**. If any person or persons knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, and such statements materially affect either the acceptance of the risk or the hazard assumed by the **Insurer** under this **Policy**, then this **Policy** shall not apply as to that person or persons. However, if the President, Chief Executive Officer, Chief Financial Officer or Managing Partner of the **Insured Entity** knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, and such statements materially affect either the acceptance of the risk or the hazard assumed by the **Insurer** under this **Policy**, then this **Policy** shall not apply as to that person or persons and the **Insured Entity**;
- the information contained in this Proposal Form shall not be used by the **Insureds** as notice as provided for in section VII. of the Common Policy Terms and Conditions Section of this **Policy**;
- this Proposal Form has been completed as respects the entire Insured Entity;
- the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

_____ Dated _____ President, Chief Executive Officer, Chief Financial Officer, or Managing Partner (Signature)

_____ President, Chief Executive Officer, Chief Financial Officer, or Managing Partner (Print Name)

_____ Title

_____ Dated _____ Human Resources Manager, or equivalent position (Signature)

This Berkley Insurance Company Proposal Form, including any material submitted herewith, shall be held in strictest confidence.

A POLICY CANNOT BE ISSUED UNLESS THE PROPOSAL FORM IS PROPERLY SIGNED AND DATED.

Please submit this Proposal Form including appropriate documentation to:
Monitor Liability Managers, 2850 West Golf Road, Suite 800, Rolling Meadows, IL 60008-4039

NOTICE TO COLORADO APPLICANTS: 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 OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO NEW MEXICO, PENNSYLVANIA APPLICANTS: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO APPLICANTS OF KENTUCKY: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER 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.

NOTICE TO APPLICANTS OF NEW JERSEY AND OKLAHOMA: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO MAINE, MASSACHUSETTS, TENNESSEE, VIRGINIA, AND WASHINGTON APPLICANTS: 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.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO APPLICANTS OF 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.

NOTICE TO ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, AND RHODE ISLAND APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.