Medical Providers Protection for Employment Practices Liability

MEDICAL PROVIDERS PROTECTION FOR EMPLOYMENT PRACTICES LIABILITY RENEWAL APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY THE OWNER, PRINCIPAL OR PARTNER 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 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: _____