



MANAGEMENT LIABILITY INSURANCE RENEWAL PROPOSAL FORM FOR EMPLOYMENT PRACTICES LIABILITY

CLAIMS MADE AND REPORTED WARNING FOR APPLICATION: This Proposal Form is for a Claims Made and Reported Policy, relating to claims made and reported 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 quotations 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 County State Zip Code

LIMIT AND DEDUCTIBLE 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.

<u>Type of Coverage</u>	<u>Carrier</u>	<u>Expiration Date</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>
Directors and Officers Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Employment Practices Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Fiduciary 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 canceled or non-renewed? (NOT APPLICABLE IN MISSOURI) Yes No

GENERAL INFORMATION

4. (a) Form of Organization:
- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Corporation | <input type="checkbox"/> Joint Venture* |
| <input type="checkbox"/> Limited Liability Corporation | <input type="checkbox"/> Nonprofit | <input type="checkbox"/> Partnership* |
| <input type="checkbox"/> Sole Proprietorship / Individual | <input type="checkbox"/> Other _____ | |

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

- (b) Type of Organization:
- | | | |
|---|--|---|
| <input type="checkbox"/> Manufacturing / Production | <input type="checkbox"/> Public Administration | <input type="checkbox"/> Retail Trade |
| <input type="checkbox"/> Service Industry | <input type="checkbox"/> Web Based | <input type="checkbox"/> 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: _____

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":

Period Ending: / /

Total Assets: \$ _____

Shareholder Equity: \$ _____

Annual Revenues: \$ _____

Net Income / Loss: \$ _____

Cash Flow From Operations: \$ _____

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 9. THROUGH 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>Non-Profit</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 regarding 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, National Labor Relations Board 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 investigation by the Internal Revenue Service, Department of Labor, Pension Benefit Guarantee Corporation, or any other local, state or federal agency? Yes No
- e. any intellectual property disputes, including Copyright, Patent, or Trademark Laws? Yes No
- f. any Security Law or Regulation? Yes No
- g. any Anti-Trust or Fair Trade Law? Yes No

14. During the last 5 years, has any "Insured", including any "Subsidiary", been involved in any lawsuit not disclosed above that would fall within the scope of the proposed insurance? 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 "Employees" does the "Insured Entity" employ in California? _____

(c) How many "Employees" does the "Insured Entity" employ outside of the U.S.? _____

(d) How many Leased Employees does the "Insured Entity" employ annually? _____

(e) How many Independent Contractors does the "Insured Entity" utilize annually? _____

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

16.

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"/> I-9 Verification |
| <input type="checkbox"/> Adherence to Employment "at-will" relationship with all "Employees" | <u>Employers with more than 50 Employees</u> |
| <input type="checkbox"/> Anti-Discrimination Equal Employment Opportunity Policy | <input type="checkbox"/> Family Medical Leave Act |
| <input type="checkbox"/> Anti-Harassment Policy, including Sexual Harassment | <u>California Employers Only</u> |
| <input type="checkbox"/> Social Media Policy | <input type="checkbox"/> California Family Rights Act |

20. Does the "Insured Entity" :

- | | |
|---|--|
| 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 |

(For question 20, details to Yes or No answers are not required by attachment.)

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;
- 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)

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

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 AND ALL OTHER STATES 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.

The Maxum Casualty Insurance Company Proposal Form, including any material submitted herewith, shall be held in strictest confidence.

Please submit this Proposal Form including appropriate documentation to:
Maxum Casualty Insurance Company, 3655 North Point Parkway, Suite 500, Alpharetta, GA 30005