EMPLOYMENT PRACTICES AND DISCRIMINATION
ERRORS AND OMISSIONS LIABILITY INSURANCE
APPLICATION
Claims Made Basis

1. Name of Employer Applicant _____

2. Address _____

3. City _____ State _____ Zip Code _____ County _____

   Tel. ( ) _____

4. Business of Employer Applicant: _____

5. Complete list of all subsidiary operations or corporations to be included as additional insureds. Also, list any D.B.A.'s and type of business, if different from answer in (4) above. Attach separate listing, if necessary. Note: ***Only those entities listed in this application will be considered for coverage***. U. S. Risk indication of terms reflects the operations to be included within coverage, if bound.

Name	Business/Type of Operations	Location	% of ownership	Date acquired/created	Number of Employees

6. The Employer Applicant has continually been in business since (provide date): _____

7. Race and Sex of work force for all entities proposed for insurance: _ _____ %Male _____ %Female

   _____ % White _____ % Black ____ %Hispanic _____ %Asian _____ %American Indian _____ %Other

8. Please complete the following Employee information reflecting the **total** number of employees by salary range: (Include all employees shown in questions #1 and #5)

Salary Range	Hired during past 12 months	Voluntary Terminations Past 12 Months	Involuntary Terminations past 12 months
0-25,000			
25,001-50,000			
50,001-100,000			
100,001-200,000			
200,001 +			

If Employer Applicant is a law firm, how many are partners (not listed above): _____

Salary Range	Total Currently Employed
0 – 25,000	
25,001-50,000	
50,001-100,000	
100,001-200,000	
200,001 +	

Number of leased employees : _____

Number of seasonal or part-time employees: _____

Are any employees union members? ____Yes ____No
How many? ___

If the Employer Applicant is a law firm, how many are partners (not listed above): _____

9. Please complete the following:

For last 12 months ending: _____

Total Assets: $_____ Revenues: $_____

Working Capital: $_____ Net Income: $_____

Long Term Debt: $_____

Net Worth: $_____

10. The Officer of the Employer Applicant designated to receive any and all notices from the Company or its authorized representative concerning this insurance is (Name and Title) _____

_____

11. Do you have a full time Director of Personnel or other similar position? ____Yes ____No If yes, please advise:

_____

Name Title

If not, who is responsible for employment relations:

_____

Name Title

12. Have you acquired or merged with any companies or have you been acquired by another company in the last 5 years?
____Yes ____No

A. With respect to any acquisitions within the past 5 years, were any employees or officers terminated?
____Yes ____No

B. Do you plan termination, suspension or demotion of any employees or officers in the next 18 months?
____Yes ____No

13. Do you anticipate any lay-offs or reduction in staff of 20% or more in the next 18 months? ____Yes ____No
(If yes, provide explanation) _____

14. Are you considering any potential or planned salary adjustments or working hour changes in the next 12 months?
____Yes ____No (If yes, provide explanation) _____

15. Have there been any employee layoffs, terminations, workforce reductions, or retirements, including those resulting from any type of company restructuring or office, branch or facility closing, within the last twelve months? ____Yes ____No
If yes, attach full details, including the date, number of employees involved, job categories involved and the terms of severance.

16. If you require physical examinations of job applicant, do you do so only after a conditional offer of employment has been made? ____Yes ____No (No physical examination is required)

17. Does the Employer Applicant or any of those subsidiaries listed in 5. above, use an employment application form which complies with Federal and/or State anti-discrimination laws?
____Yes ____No (Please attach copy)

18. Has the Employer Applicant or any of those subsidiaries listed in 5. above established written guidelines or a procedure manual for the hiring, firing, promotion or demotion of any employee or prospective employee? ____Yes ____No
(If yes, please attach a copy of said guidelines or manual.)

Is it distributed to all employees? ____Yes ____No

19. Does the manual include policies on:

anti-discrimination?	____Yes	____No
anti-sexual harassment?	____Yes	____No
ADA?	____Yes	____No
FMLA?	____Yes	____No

20. Have you developed an action plan to implement changes in your firm required to comply with the Americans with Disabilities Act and the Family Medical Leave Act?

____Yes ____No (If no, please explain.) _____

21. Have those responsible for hiring received instruction, including interview training on Americans with Disabilities Act, sexual harassment and discrimination concerns? ____Yes ____No (If no, please explain.)

_____

22. Current Employment Practices or Discrimination Liability Insurance:

a. Name of insurer:_____

b. Limit:_____ c. Retention:_____

d. Annual Premium: $_____ e. Expiration Date _____

f. Retroactive date:_____

23. Has any insurer refused or cancelled coverage in respect of Discrimination Liability Insurance Coverage?
____Yes ____No (If yes, please attach full details).

24. Has the Employer Applicant, any of those subsidiaries listed in 5. above, or any director or officer or employee thereof, within the past five years been the subject of any suit, inquiry, administrative proceeding or investigation by any local, state or federal agency or governmental entity in connection with charges of discrimination including, but not limited to, such charges based upon race, religion, sex, national origin, handicapped status, age, sexual orientation or sexual harassment or wrongful termination? ____Yes ____No (If yes, please attach full details).

25. Is the Employer Applicant or any Officer having responsibility over such matters aware of any circumstance likely to give rise to a claim or suit for wrongful termination or for discrimination based on race, religion, sex, national origin, handicapped status, age, sexual orientation or sexual harassment? ____Yes ____No (If yes, please attach full details).

26. If insurance similar to that now proposed had ever been in force, no claim which would have fallen within the scope of such insurance has been made or is now pending against any of the individuals or corporations proposed for insurance except as follows: (if none, so state) _____

27. Are any of the individuals or corporations proposed for insurance aware of any circumstance(s), situation(s) , or event(s) which there is reason to believe might afford grounds for any future claim such as would fall within the scope of the proposed insurance? ____Yes ____No (If yes, please attach full details).

The undersigned authorized Officer of the Employer Applicant declares that to the best of his/her knowledge and belief the statements set forth herein are true. Although the signing of this Application does not bind the undersigned to effect Insurance the undersigned, on behalf of all individuals, partnerships and corporations proposed for insurance, agrees that this form and the said statements shall be the basis of the contract and that the Underwriters have relied on the correctness thereof, should a policy be issued and this application and any attachments shall attach to and become part of any such contract.

Arkansas Residents: 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.

Signed _____

Capacity _____

Corporation _____

Date _____

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Limit of Liability Desired: _____ $300,000 _____ $500,000 _____ $1,000,000

Deductible Level Desired: ___ $2,500 ___ $5,000 ___ $7,500 ___ $15,000 ___ $25,000 ___ Other

Desired Effective Date :_____

INDIVIDUAL CLAIM DATA REPORT

APPLICANT'S INSTRUCTIONS:

1. This form is to be completed by Applicant regarding any claim or suit during the past five (5) years or any facts, circumstances, acts, errors, or omissions of which applicant is aware which may give rise to a claim. COMPLETE ONE FORM FOR EACH SUCH CLAIM OR CIRCUMSTANCE.
2. If additional "Individual Claim Data Reports" are required, please photocopy blank report.
3. If space is insufficient to answer any question fully, attach a separate sheet.
4. Answer all questions completely.

(PLEASE TYPE OR PRINT)

1. Full name of Applicant:

   _____

2. Full name of individual(s) involved or named in the claim:

   _____

3. Full name of Claimant:

   _____

4. Indicate whether: Claim/suit:_____ Incident: _____
5. Date of alleged error:_____ Date of claim: _____
6. Additional defendant (if any):

   _____

7. IF CLOSED:

   Total Loss Paid including Deductible: $_____

   Legal Expenses Paid: $_____

8. IF PENDING:

   Claimant's settlement demand $_____ Loss reserves $_____

   Defendant's offer of settlement $_____ Loss paid to date $_____

   Expense reserves $_____ Expenses paid to date $_____

   Deductible $_____ Is claim in suit: Yes_____ No_____

   If Yes, Amount asked in summons? $_____

9. Name of Insurer (if any) :_____
10. Description of claim: (Provide enough information to allow evaluation and use back of this page or separate exhibit if additional space is required.)

    A. Alleged act, error or omission upon which claimant bases claim:

    _____

    _____

    B. Description of the type and extent or injury or damage allegedly sustained:

    _____

    _____

11. What preventative measures has the applicant implemented to ensure claims will not occur in the future?

    _____

I understand information submitted herein becomes a part of the proposal and is subject to the same warranty and conditions.

Signature of Applicant_____ Date _____