Utica National Insurance Group

Insurance that starts with you.

Utica Mutual Insurance Company and its affiliated companies, New Hartford, N.Y. 13413

RESET

EMPLOYMENT - RELATED PRACTICES LIABILITY INSURANCE APPLICATION

THIS IS AN APPLICATION FOR A CLAIMS-MADE POLICY. SEE NOTICE ON PAGE 5. READ YOUR POLICY CAREFULLY.

THE POLICY INCLUDES DEFENSE COSTS IN ITS LIMITS OF INSURANCE. ANY DEFENSE COSTS PAID UNDER COVERAGE WE PROVIDE WILL REDUCE THE AVAILABLE LIMITS OF INSURANCE UNDER THAT COVERAGE AND MAY EXHAUST THEM COMPLETELY.

Named Insured:_____ Producer:_____

Mailing Address:_____ Producer No:_____

City: _____State: ____ Zip:_____ License No:_____

Policy Period:_____ to _____

I. CORPORATE HISTORY

1) Describe the firm's operations:

2) Number of years in business? _____

3) Have you had any plant, facility, branch or office closings, consolidations, layoffs or staff reductions (greater than 10% of the workforce), mergers or acquisitions within the past 24 months or, do you anticipate any of the above within the next 12 months? ☐ Y ☐ N

If yes, please provide details on the supplemental application attached.

4) Does the organization have any contracts with or receive financial assistance from the Federal Government? ☐ Y ☐ N

If yes, please provide details on the supplemental application attached.

II. EMPLOYEES

5) By state, please list the total number of locations and employees, broken down by Full time employees (FT), Part time employees* (PT), Temporary/Leased workers (TL), and Independent contractors** (IC) for each of the last 3 calendar years:

1. Last Full Year (1/1 thru 12/31)						**2. Last Full Year Prior to 1.**					
	Number of	**Employees**					**Number of**	**Employees**			
State	**Locations by State**	**# FT**	**# PT**	**# TL**	**# IC**	**State**	**Locations by State**	**# FT**	**# PT**	**# TL**	**# IC**
Totals						**Totals**					

3. Last Full Year Prior to 2.					
State	Number of Locations by State	# FT	# PT	# TL	# IC
Totals					

* Defined as employees working less than 32 hours per week (1600 hours per year).

** Independent Contractors are not covered under the basic policy, but their use must be reported. If you desire coverage for potential claims by independent contractors, please use the Supplemental Application attached.

6) Percent of workforce that have been union members in the last three calendar years:
Last _____ First Prior _____ Second Prior _____

7) Breakdown of current Full Time employees by their total cash compensation (salary + bonus):

Salary ranges	# of Employees	% of total
$30,000 or less per year		
$30,001 - $100,000 per year		
Over $100,000 per year		
Total		

8) Turnover
Number of Full Time and Part Time employees terminating employment (whether initiated by employer or employee) during the year divided by the total at the start of the year (e.g. Total employees; at start of year = 100; Number of employees terminating employment during year = 5; 5 ÷ 100 = 5%):
Last full calendar year _____ % Next Prior _____ % Next Prior _____ %

9) Total number of employer initiated terminations of F/T and P/T employees for last three calendar years:
Last full calendar year _____ Next Prior _____ Next Prior _____

III. LOSS HISTORY

10) Within the last 5 years has the firm, inclusive of predecessor firms, or any individual proposed for this insurance:

a) received any employment related inquiry, complaint or charge from any municipal, state, or federal regulatory authority or any other governmental entity? ☐ Y ☐ N

b) had a claim, suit, grievance, or demand been brought against them? ☐ Y ☐ N

If yes to either, explain each on the supplemental application attached:

11) Are you aware of any facts, incidents, or circumstances which may result in a claim(s) being made against you? ☐ Y ☐ N

If yes, explain on the supplemental application attached.

THE APPLICANT UNDERSTANDS AND AGREES THAT IF ANY FACTS, INCIDENTS, OR CIRCUMSTANCES ARE KNOWN WHICH MAY REASONABLY GIVE RISE TO A CLAIM UNDER THIS PROPOSED POLICY, THEN ANY CLAIMS ARISING FROM SUCH FACTS, INCIDENTS, OR CIRCUMSTANCES ARE EXCLUDED FROM COVERAGE THEREUNDER. FAILURE TO DISCLOSE SUCH KNOWN FACTS, INCIDENTS OR CIRCUMSTANCES HERE WILL VOID THE PROPOSED POLICY IN ITS ENTIRETY.

IV. HUMAN RESOURCES FUNCTION

12) a. Who is responsible for the Human Resources or Personnel functions?

Name _____ Title _____

b. Who is designated to handle all employment-related incidents?

Name _____ Title _____

13) Do you make use of any of the following tests screen employment applicants, to promote employees, or for the purpose of continuing employment?

a) Psychological or personality tests: ☐ Y ☐ N

b) Drug or alcohol tests ☐ Y ☐ N

c) Pre employment offer medical tests ☐ Y ☐ N

If yes, provide details on the supplemental application attached.

V. INSURANCE INFORMATION

14) Do you currently carry Employment-Related Liability Insurance?

If yes, please provide: ☐ Y ☐ N

Insurer:_____

Limit: _____ Per Claim: _____ Aggregate: _____

Policy Period: _____ Retroactive Date: _____

Retention or Deductible: _____ Co-Insurance Amount: _____

Premium: _____

15) Has any insurer ever canceled or non-renewed this type of coverage? ☐ Y ☐ N

If yes, provide details on the supplemental application attached.

16) Current GL carrier? _____

Limit of Liability _____

17) Check desired limits of liability (per claim/aggregate):

☐ $250,000/$250,000 ☐ $500,000/$500,000

☐ $1,000,000/$1,000,000 ☐ $2,000,000/$2,000,000

18) Check desired:

a) Retention (per claim) $5,000 (basic) ☐ $10,000 ☐ $25,000 ☐

b) Co-insurance Participation (per claim)

0% (basic) ☐

5% (with $25,000 per claim max) ☐ 5% (with $50,000 per claim max) ☐

10% (with $25,000 per claim max) ☐ 10% (with $50,000 per claim max) ☐

VI. RISK MANAGEMENT PRACTICES

19 a) Have all your employment related policies and procedures been reviewed and approved by outside counsel? ☐ Y ☐ N

If yes, when? _____

By whom? Firm: _____ Atty: _____

Does this firm, or attorney used for review, specialize in employment law? ☐ Y ☐ N

b) Have all recommendations from that review been implemented? ☐ Y ☐ N

If not, explain or provide time frame for implementation on supplemental application attached.

20) Do you use an employment application during your hiring process? ☐ Y ☐ N

If yes, does it contain:

a. An employment at will statement? ☐ Y ☐ N
b. Authorization to check references & criminal conviction records? ☐ Y ☐ N
c. The applicant's signature attesting that all representations are true? ☐ Y ☐ N
d. An equal employment opportunity statement? ☐ Y ☐ N

21) Do you distribute an employment handbook to your employees? ☐ Y ☐ N

If yes, does it contain:

a. an employment at will statement? ☐ Y ☐ N
b. a written equal employment opportunity statement? ☐ Y ☐ N
c. a written anti-sexual and general harassment policy? ☐ Y ☐ N
d. a written internal complaint procedure for discrimination and sexual harassment claims? ☐ Y ☐ N

If no, do you have written policies on all of the above that are distributed separately? ☐ Y ☐ N

Specify any that are not:

22) Do you have a progressive disciplinary program? ☐ Y ☐ N
If yes, is it distributed to supervisors in writing? ☐ Y ☐ N

23) Do you post, in places conspicuous to all employees and applicants for employment, all notices required by law? ☐ Y ☐ N

24) When requested by employees, do you distribute information as required by federal law regarding the Family Medical Leave? ☐ Y ☐ N

25) Do you require that all employment terminations be reviewed by the personnel having human resources responsibilities? ☐ Y ☐ N

26) Have you informed supervisory personnel, in writing, of their responsibility to provide you with prompt notice of any claims, incidents or allegations? ☐ Y ☐ N

VII. ADDITIONAL INFORMATION

Please attach each of the following, if they exist:

Employee handbook
Employee grievance, disciplinary, termination, and out-placement procedures
Employment application Form(s)
EEO and Discrimination and Sexual Harassment Policy
Separation Agreement Form

IMPORTANT CLAIMS-MADE COVERAGE NOTICE

The Coverage Form which provides Employment-Related Practices Liability Coverage applies on a claims-made basis.

The following provides a general description of this coverage and is subject to the terms and provisions of the actual Coverage Form. Terms in quotation marks are defined in the Coverage Form.

A. The Coverage Form, subject to its terms and conditions, provides full prior acts coverage if no Retroactive Date is entered in the Declarations. If a Retroactive Date is entered in the Declarations, the Coverage Form will not apply to "claims" for "employment-related practices" which took place before the Retroactive Date. The Coverage Form will not apply to "claims" for "employment-related practices" which take place after the expiration of the "policy period."

B. The Coverage Form will apply to "claims" for "employment-related practices" which took place on or after the Retroactive Date, if any, but before the beginning of the "policy period" **only if** any "claim" is made according to **D.** below.

C. The Coverage Form will not apply to any "employment-related practice" for which "claim" is first made after the expiration of the "policy period" or any Automatic or Optional Extended Reporting Period described in the Extended Reporting Period Section of the Coverage Form.

D. The Coverage Form will apply only to "claims" which are first made:

1. During the "policy period";

2. During the ninety day Automatic Extended Reporting Period described in the Extended Reporting Period Section of the Coverage Form;

3. During the five year Automatic Extended Reporting Period described in the Extended Reporting Period Section of the Coverage Form for "claims" arising out of "employment-related practices" reported, under the policy provisions, no later than ninety days after the end of the "policy period"; or

4. During the 12 month or 36 month Optional Extended Reporting Period described in the Extended Reporting Period Section of the Coverage Form. Such Optional Extended Reporting Period must be requested by the first Named Insured in writing, by the later of sixty days after the date of "termination of coverage," or thirty days after the date of mailing by us of notice to the first Named Insured advising of premiums for and provisions of the Optional Extended Reporting Periods, in order to allow "claims" to be made against the policy coverage after the expiration of an Automatic Extended Reporting Period.

E. We will send to the first Named Insured shown in the Declarations a written notice, within thirty days after any notice of "termination of coverage," of the premium for and provisions of the Extended Reporting Periods, unless we cancel for nonpayment of premium or fraudulent activities of any insured.

F. For the first three years of claims-made coverage, premiums will be comparatively lower than for occurrence coverage, and will increase for each renewal of those policies. Claims-made prices will still be somewhat lower than occurrence prices for mature accounts (in their fourth or later years). The purchase of Optional Extended Reporting Periods, as described above, requires additional premium payments.

A review of the Extended Reporting Period provisions in your policy, as summarized above, will underscore the importance of both the Automatic and Optional Extended Reporting Periods.

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE UNDERSIGNED FURTHER DECLARES THAT ANY CLAIM, INCIDENT OR EVENT TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WHICH MAY RENDER INACCURATE, UNTRUE, OR INCOMPLETE ANY STATEMENT MADE WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.

THE FIRM UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY BE ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY.

THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THIS REPRESENTATION, ON BEHALF OF THE FIRM OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES

IN 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.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, 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.

NOTE: FOR STATES THAT REQUIRE SPECIFIC FRAUD WARNING LANGUAGE, USE ACORD 63 FRAUD STATEMENTS, WHICH MUST BE READ AND SIGNED BY THE APPLICANT AND ATTACHED TO EACH COPY OF THE APPLICATION REQUIRED TO BE SUBMITTED.

Signatures of:
Sole Proprietor, Partner, Manager (if Limited Liability Company), or President or Chairman (if Corporation):

_____

Dated: _____

Individual responsible for Human Resources function: _____

Dated: _____

NOTE: The attached Supplemental Application must be completed if you have provided any "yes" responses to questions 3, 4, 10, 11, 13, 15 or 19 above or if you are interested in coverage for independent contractors.

Supplemental Application

3) Details of plant, facility or branch office closings, consolidations, layoff/staff reductions (greater than 10% of the workforce), mergers or acquisitions within the past 24 months

Details on any of the above anticipated in the next 12 months

4) Description of contracts with the Federal Government, including revenue size and any financial assistance.

Is there an affirmative action plan? ☐ Y ☐ N

If yes, please attach a copy and describe reason for implementing.

5) Details of all independent contractor contracts for which you would want coverage under this insurance for claims brought by such contract workers. Include number of workers, type of work, approximate average hours/week and/or months of use, and whether workers are primarily on site or off.

10) a. Details of any employment-related inquiry, complaint, charge, from any municipal, state, or federal regulatory authority or any other governmental entity within the last 5 years: (Provide date, complete description, amount demanded, and amount paid and/or reserved.)

b. Details of any claim, suit, grievance, or demand within the last 5 years:
(Provide date, complete description, amount demanded, and amount paid and/or reserved.)

11) Details of any facts, incidents, or circumstances which may result in a claim(s) being made against you:

13) Tests used to screen employment applicants, to promote employees, or for the purpose of continuing employment.

Describe:

a) type of test;
b) how the test is administered, i.e.: to all employees or segments of, please detail procedures; and
c) Company creating test and validation documentation.

15) Details of canceled Employment-Related Practices Liability Insurance:

Carrier: _____ Cancellation Date: _____
Reason:

19) Explain any recommendations made by outside counsel which have not been implemented, and reason why or timeframe to complete.