



Return application to:
 CB Malaga Insurance Services LLC
 tel: 877-245-5887
 fax: 805-426-8540
 email: info@cbspecialty.com

Wrap +®
**Employment Practices Liability
 Coverage Application**

Travelers Casualty and Surety Company of America

Travelers Casualty and Surety Company (only applicable in Guam, Puerto Rico, and the Virgin Islands)

NOTICE

ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST INSUREDS DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED BY THE AMOUNTS INCURRED AS DEFENSE EXPENSES, AND DEFENSE EXPENSES WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY CLAIM UNLESS DUTY-TO-DEFEND COVERAGE IS SPECIFICALLY PROVIDED.

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

I. GENERAL INFORMATION

1. **Applicant** Information:

Name of **Applicant**: _____

Street Address: _____

City, State, ZIP Code: _____

Website Address: _____

Year **Applicant's** business was established: _____

Description of **Applicant's** operation: _____

2. **Applicant's** Standard Industrial Classification (SIC) code, if known (4-digit number): _____

3. Is the **Applicant** a subsidiary of a foreign parent? Yes No

4. Does the **Applicant** currently file, or does it anticipate filing in the next 6 months, any documents with the Securities and Exchange Commission, or similar foreign authority regarding any equity or debt securities? Yes No

II. ORGANIZATION INFORMATION

1. List and describe all entities in which the **Applicant's** ownership interest is 50% or greater or over which the **Applicant** has management control (Check here if not applicable):

Name	% Owned	Year Started	Description of Operations	Entity Type*
	%			
	%			
	%			

*Entity Type: FP=For-Profit (other than Partnership); NP=Non-Profit; GP=General Partnership; LP=Limited Partnership; LLC=Limited Liability Company

To enter more information, please attach a separate page or an organization chart.

2. In the next 12 months (or during the past 24 months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) the following:

a. Any actual or proposed merger, acquisition, or divestiture? Yes No

b. Any creation of a new business, subsidiary or division? Yes No

- c. Any registration for a public offering or a private placement of securities? Yes No
- d. Any reorganization or arrangement with creditors under federal or state law? Yes No
- e. Any branch, location, facility, office, or subsidiary closings, consolidations or layoffs? Yes No

If any of the questions above were answered Yes, please attach an explanation, including the timing, the essential terms of the event, arrangement, impact on employee base, and the surrounding circumstances.

III. FINANCIAL INFORMATION

1. Is the **Applicant** currently (or has it been in the past 24 months) in violation of, or has it received an amendment to any debt covenant? Yes No
 If Yes, please attach an explanation.

Note: Omit Question 2 if the **Applicant** is required to submit a separate financial statement as directed in the Required Attachments section.

2. Complete the following chart providing the requested financial information:

Indicate the following as it relates to the Applicant's fiscal year end (FYE): (Please indicate negative figures with "()" or "-" as appropriate)	Most Recent FYE (Month/Year) (____ / ____)	Prior FYE (Month/Year) (____ / ____)
Current Assets	\$	\$
Total Assets	\$	\$
Current Liabilities	\$	\$
Long Term Debt	\$	\$
Retained Earnings (Accumulated Deficit/Fund Deficit)	\$	\$
Net Equity/Net Assets (Deficit Equity)	\$	\$
Revenues	\$	\$
Net Income (Net Loss)	\$	\$

IV. EMPLOYEE INFORMATION

1. Total number of employees*: _____
2. What percentage of the **Applicant's** employee base is outside the U.S.? _____ %
3. Total number of locations: _____
4. Complete the following chart providing the number of Full Time and Part Time employees*, Volunteers and natural person Independent Contractors:

As of Date of Application		Previous 12 Months		As of Date of Application	
Full Time Employees	Part Time Employees	Full Time Employees	Part Time Employees	Volunteers	Independent Contractors

*Full and part time including leased, seasonal, and temporary employees

5. Complete the following chart providing the *maximum* number of employees at any one point during the previous 12 months for the following classifications (regardless of whether they are full or part time):

Leased	Temporary	Seasonal	Union

6. Complete the following chart providing employee information for the 5 states or countries with the greatest number of **Applicant** employees:

State or Foreign Country Location	Number of Employees

7. Number of employees:

a. Compensated **less than** \$50,000 annually: _____

b. Compensated **more than** \$100,000 annually: _____

8. Within the past 24 months has the **Applicant** or outside employment counsel completed an audit regarding the payment of wages, including equal pay and overtime pay? Yes No

9. What percentage of the **Applicant's** employee base is: Exempt _____%
Nonexempt _____%

10. Within the past 24 months has the **Applicant** or outside employment counsel completed an audit regarding the classification of individuals as exempt v. non-exempt employees or as independent contractors? Yes No

11. Complete the following chart providing employee turnover figures for each of the last 3 years:

Number of Terminations	Year - 20____	Year - 20____	Year - 20____
Voluntary			
Involuntary (excluding layoffs/downsizing)			
Layoffs/Downsizing			

12. Within the past 24 months how many officers have been involuntarily terminated or laid off? _____

13. Prior to employee terminations does the **Applicant** consult with:

a. Human Resources personnel? Yes No

b. An attorney with experience in employment law? Yes No

14. a. Does the **Applicant** provide severance packages to terminated or laid off employees? Yes No

b. If Yes, does the severance agreement include a waiver or release of an employee's rights to bring claim against the **Applicant**? Yes No

V. HUMAN RESOURCES

1. Does the **Applicant** have a Human Resources department? Yes No

Number of Human Resource employees: _____

2. Are all prospective employees required to complete a uniform employment application prior to hire? Yes No

3. Does the **Applicant** have an employee handbook that is distributed to all employees? Yes No

4. Are employees required to acknowledge, by signature, receipt of such employee handbook? Yes No

5. Does the employment application or employee handbook contain an "Employment at Will" statement? Yes No

6. Complete the following chart for guidelines, policies and procedures related to the following:

Guidelines, Policies, Procedures	Formal Written Policy	Employees Sign and Acknowledge Receipt
Discrimination	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexual and Other Workplace Harassment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Equal Employment Opportunity	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
FMLA	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disabled Employees and Accommodations	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Retaliation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Reporting, Investigating and Resolving Employee Complaints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Employee Discipline	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Written Performance Appraisals/Reviews	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Salary Administration	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Hiring/Interviewing	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Discharge/Termination	Yes <input type="checkbox"/> No <input type="checkbox"/>	

7. Are the **Applicant's** employment practices policies, procedures and employee handbook periodically reviewed by an attorney with experience in employment law? Yes No
8. Does the **Applicant** have written policies or procedures outlining employee conduct when dealing with the general public, customers, clients, vendors, or other third parties? Yes No
9. Does the **Applicant** have written policies or procedures for dealing with complaints from the general public, customers, clients, vendors, or other third parties for issues involving harassment or discrimination? Yes No
10. Does the **Applicant** conduct human resources training on guidelines, policies and procedures for all individuals who handle human resources functions? Yes No
11. Does the **Applicant** conduct training for employees on issues of discrimination and sexual and other workplace harassment? Yes No
12. If the **Applicant** is a federal contractor subject to the OFCCP, has the **Applicant** been subject to a compliance evaluation or investigation in the last 3 years?
If Yes, please attach an explanation. N/A Yes No

VI. CURRENT INSURANCE INFORMATION/REQUESTED INSURANCE TERMS

Requested Limit (A)	Requested Retention (B)	Requested Effective Date (C)	Coverage Currently Purchased (D)
\$	\$		Yes <input type="checkbox"/> No <input type="checkbox"/>

Expiring Limit (E)	Expiring Retention (F)	Expiring Premium (G)	Current Insurer (H)	Date Coverage First Purchased (I)
\$	\$	\$		

1. What is the **Applicant's** preference for defense coverage? Duty to Defend Reimbursement
2. Is coverage requested for Third Party Claims? Yes No
3. Is Third Party coverage currently included? Yes No

4. If Liability Coverage is currently purchased as indicated in Column (D) above, but has been in place for less than 3 years, please answer the following question:

As of the date the **Applicant** first purchased the Liability Coverage, is the **Applicant** or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim being made against them under the Liability Coverage for which the **Applicant** is applying?

Yes No

If Yes, please attach an explanation.

5. If Liability Coverage is not currently purchased as indicated in Column (D) above, please answer the following question:

Is the **Applicant**, or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under the Liability Coverage for which the **Applicant** is applying?

Yes No

If Yes, please attach an explanation.

6. If Liability Coverage is currently purchased but does not include Third Party coverage, and such coverage is being requested, please answer the following question:

Is the **Applicant**, or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under Third Party coverage for which the **Applicant** is applying?

Yes No

If Yes, please attach an explanation.

7. If the Requested Limit in Column (A) exceeds the Expiring Limit in Column (E), please answer the following question:

Solely with respect to any higher limits requested or that may ultimately be issued for the proposed insurance, is the **Applicant** or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under the Liability Coverage for which the **Applicant** is applying?

Yes No

If Yes, please attach an explanation.

*With respect to the information required to be disclosed in response to the questions above, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of the **Applicant** had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy.*

VII. LOSS INFORMATION

1. Have any employment-related claims or administrative, criminal or regulatory proceedings, charges, hearings, demands or lawsuits been made against the **Applicant** or any person proposed for this insurance during the past 3 years, whether or not insured, including claims involving employees or independent contractors?

Yes No

If Yes, please complete the table below.

2. Has any claim, demand or lawsuit been made against the **Applicant** or any person proposed for this insurance involving sexual harassment or discrimination brought by the general public, customers, clients, vendors or other third party?

Yes No

If Yes, please complete the table below:

Date of Such Claim	Nature of Claim	Amount Paid for Defense	Amount Sought or Paid for Damages	Covered by Insurance?	Corrective Procedures Implemented	Current Status
		\$	\$	Yes <input type="checkbox"/> No <input type="checkbox"/>		
		\$	\$	Yes <input type="checkbox"/> No <input type="checkbox"/>		

To enter more information, please attach a separate page to the Application.

VIII. REQUIRED ATTACHMENTS

As part of this Application, please submit the following documents (*these documents, and the representations and facts they contain, are made a part of this Application, whether such documents are physically delivered to the Company by the Applicant or are obtained by the Company from any public source, including the Internet*):

- Employee Handbook, if **Applicant** has 500 or more employees
- Most recent EEO-1 report, if **Applicant** has 1,000 or more employees
- Most recent annual financial statement, if policy limit requested is \$3,000,000 or greater
- Construction Supplemental Application, if **Applicant** is a contractor
- Downsizing Supplemental Application, if impact of **Applicant** layoffs is either 10% of the workforce or more than 100 employees
- Wage and Hour Supplemental Application, if **Applicant** has 1,000 or more employees

IX. COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

X. FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island

Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Colorado

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

Attention: Insureds 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.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania

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. (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.)

Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and 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.

Attention: Insureds in Oregon

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Puerto Rico

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

XI. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PARTNER, PRINCIPAL, HEAD OF HUMAN RESOURCES, GENERAL COUNSEL OR OTHER OFFICER ACCEPTABLE TO TRAVELERS) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Signature* of **Applicant's** Authorized Representative
(Partner, Principal, Officer, Head of Human Resources
or General Counsel)

Name (Printed)

Title

Date

***IF YOU ARE ELECTRONICALLY SUBMITTING THIS APPLICATION TO TRAVELERS, APPLY YOUR ELECTRONIC SIGNATURE TO THIS FORM BY CHECKING THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX BELOW. BY DOING SO, YOU HEREBY CONSENT AND AGREE THAT YOUR USE OF A KEY PAD, MOUSE, OR OTHER DEVICE TO CHECK THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX CONSTITUTES YOUR SIGNATURE, ACCEPTANCE, AND AGREEMENT AS IF ACTUALLY SIGNED BY YOU IN WRITING AND HAS THE SAME FORCE AND EFFECT AS A SIGNATURE AFFIXED BY HAND.**

AUTHORIZED REPRESENTATIVE'S ELECTRONIC SIGNATURE AND ACCEPTANCE

XII. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE):

Producer Signature

Producer Name (Printed)

Agency Name

Agency Code

License Number