MEDICAL PROVIDERS EMPLOYMENT PRACTICES LIABILITY PROTECTION APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY THE CHAIRPERSON OR PRESIDENT 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 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 acquistion 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: _____