



**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. Person to receive all notices on behalf of the Insured: \_\_\_\_\_  
 Title: \_\_\_\_\_ Email Address: \_\_\_\_\_
3. Do you have more than one location?  Yes  No  
 If yes, attach a list of all locations, including the address and the number of employees at each site.
4. Nature of Operations:  Clinic  Medical Office  Dental Office  Other: \_\_\_\_\_  
 Area of Specialty(ies): \_\_\_\_\_
5. Number of years in operation: \_\_\_\_\_ If less than 3 years, provide resumes of the Owners/Principals/Partners/Key management confirming prior experience)
6. Is the Applicant a subsidiary of another Organization?  Yes  No  
 Name of Parent: \_\_\_\_\_ Location: \_\_\_\_\_
7. Total number of employees
 

	Current 12 months	Prior 12 months	Anticipated next 12 months (If operating less than 3 years)
Full Time: (Other than Employed Doctors)	_____	_____	_____
Part Time: (Other than Employed Doctors)	_____	_____	_____
Employed Doctors (Not Principals or Partners)	_____	_____	_____
Temporary/ Seasonal:	_____	_____	_____
Independent Contractors:	_____	_____	_____
Leased	_____	_____	_____
8. How many employees have been involuntarily terminated in the past 12 months? \_\_\_\_\_ 24 months? \_\_\_\_\_
9. Has the Organization closed, downsized, laid off, reduced staff, sold, merged or acquired any company in the past 12 months?  Yes  No  
 Does the Organization anticipate doing so in the next 12 months?  Yes  No  
 If yes, please attach details.
10. Percentage of employees (not including employed doctors) with total compensation including salaries, bonuses and commissions over \$75,000 \_\_\_\_\_%
11. Does the Organization currently carry Employment Practices Liability Insurance?  Yes  No  
 If Yes, provide the following:

Name of Insurer	Limits	Policy Period	Deductible/Retention	Premium	Retroactive date

12. Does the Organization want any subsidiary(s) covered?  Yes  No  
 If yes, provide name(s), nature of operation, number of employees and the percentage of ownership the organization has in the subsidiary(s).  
 \_\_\_\_\_  
 \_\_\_\_\_
13. Has the Organization or any individual proposed for linsurance ever denied medical or dental services to any person based, in whole or in part, on race, creed, color, sex, sexual orientation, age, national origin, or disability?  Yes  No  
 If yes, please attach details on a separate sheet.
14. Has the Organization or any individual proposed for Insurance ever denied medical or dental services or have a policy against providing medical or dental services to an individual because of their communicable disease including but not limited to HIV/AIDS?  Yes  No  
 If yes, please attach details on a separate sheet.
15. Within the last 5 years has any complaint, inquiry, notice of a hearing, claim or suit been made against the Organization or any person proposed for Insurance as a result of an alleged Sexual Misconduct to a Patient?  Yes  No  
 If yes, please attach details on a separate sheet.

16. Within the last 5 years has any employment related, or third party discrimination, or third party sexual harassment: inquiry, complaint, notice of hearing, claim or suit been made against the Organization or any person proposed for Insurance in the capacity of either Director, Officer or Employee of the Organization?  Yes  No

**If "Yes," please complete a United States Liability Insurance Group claim supplement for each claim.**

17. Is any person proposed for this Insurance aware of any fact, circumstance or situation which may result in an employment claim or third party discrimination or third party sexual harassment claim against the Organization or any of its Directors, Officers or Employees?  Yes  No

**If "Yes," please complete a United States Liability Insurance Group claim supplement for each claim.**

18. Do you have an Email/Internet Policy currently in place?  Yes  No  
If no, are you willing to implement one? (Sample can be provided by the Company)  Yes  No

Please submit a copy of current or newly implemented policy within 21 days after the inception date of this insurance.

**MANDATORY WRITTEN EMPLOYMENT POLICIES.** Please identify policies applicant has in place:

- Anti-Harassment Policy  Yes  No
- Anti-Discrimination Policy  Yes  No
- Third Party Discrimination Policy  Yes  No

**Please forward copies of the policies identified above along with this signed and dated application.** If you do not have these written policies in place, the Company will provide you with sample policies at the time of binding this insurance.

As a condition precedent to issuance of the Policy for Insurance, the Applicant agrees:

- 1) to implement and distribute to each employee the Mandatory Anti-Harassment and Anti-Discrimination Policies which are currently not in place as soon as possible, but no later than 21 days after the inception date of this insurance. Failure of the Company to receive these policies within 21 days after the inception date of this insurance will result in rescission of the binder for this insurance.
- 2) to adopt and distribute to each employee all changes required by the Company to the Applicant's Written Policies, as soon as possible, but no later than 21 days after receipt of notice of the changes required by the Company.

**Recommended Written Employment Policies.** Please identify policies Applicant has in place:

- Employment Application  Yes  No  
If Applicant has an Employment Application or Company Email/Internet Policy, a copy must be forwarded for review by the Company as soon as possible, but no later than 21 days after the inception date of this insurance. Failure of the Company to receive this application within 21 days after the inception date of this insurance will result in rescission of the binder for this insurance.
- Employee Handbook  Yes  No
- Contains Employment-At-Will Statement?  Yes  No
- Contains statement that Handbook is not a contract of employment?  Yes  No

**Fraud Statement:** 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.

If the primary address of the location listed in item #1 is in the state of **New York, Iowa or Florida**, the states of **New York, Iowa and Florida** require that we have the names and address of your (insured's) authorized Agent or Broker.

Name of authorized Agent or Broker: \_\_\_\_\_

Address: \_\_\_\_\_

Agent or Broker License Number: \_\_\_\_\_

The undersigned represents that to the best of his/her knowledge and belief the particulars and statements set forth herein are true and agrees that those particulars and statements are material to acceptance of the risk assumed by the Company. The undersigned further declares that any changes to the information contained in this application 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 Company and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The Company is hereby authorized, but not required to make any investigation and inquiry in connection with the information, statements and disclosures provided in this application. The decision of the Company not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Company and shall not estop the Company from relying on any statement in this application. The signing of this application does not bind the undersigned to purchase the insurance, nor does the review of this application bind the Company to issue a policy. It is understood the Company is relying on this application in the event the Policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued and it will be attached and become a part of the policy.

Signature: \_\_\_\_\_  
(Owner, Principal, or Partner)

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_