

SERFF Tracking Number: CNNA-125493528 State: Arkansas
Filing Company: The Cincinnati Insurance Company State Tracking Number: EFT \$50
Company Tracking Number: CBOP-08-6009-AR
TOI: 05.1 Commercial Multi-Peril - Non-Liability Sub-TOI: 05.1002 Businessowners
Portion Only
Product Name: CBOP-08-6009-AR
Project Name/Number: /

Filing at a Glance

Company: The Cincinnati Insurance Company

Product Name: CBOP-08-6009-AR SERFF Tr Num: CNNA-125493528 State: Arkansas
TOI: 05.1 Commercial Multi-Peril - Non-Liability SERFF Status: Closed State Tr Num: EFT \$50
Portion Only

Sub-TOI: 05.1002 Businessowners Co Tr Num: CBOP-08-6009-AR State Status: Fees verified and received

Filing Type: Form Co Status: Reviewer(s): Betty Montesi, Llyweyia Rawlins, Brittany Yielding
Author: Sharon Grubbs Disposition Date: 02/28/2008
Date Submitted: 02/19/2008 Disposition Status: Approved

Effective Date Requested (New): 09/01/2008 Effective Date (New): 09/01/2008
Effective Date Requested (Renewal): Effective Date (Renewal):

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Domicile Status Comments:
Reference Organization: Reference Number:
Reference Title: Advisory Org. Circular:
Filing Status Changed: 02/28/2008
State Status Changed: 02/28/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:

At this time, we wish to file form(s) per the attached memorandum.

Final copies are attached for your review.

Filing fees will be sent through the Electronic Filing Fee System as a (EFT) filing.

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Please be advised that we work on a 90-days-in-advance schedule. As a result, we would appreciate your approval by June 1, 2008, for the software to be mailed to our agents on July 1, 2008, for the effective date of September 1, 2008.

Your approval is respectfully requested for use on policies effective on or after September 1, 2008.

Company and Contact

Filing Contact Information

Sharon Grubbs, Senior Filings Analyst sharon_grubbs@cinfin.com
 6200 S. Gilmore Road (513) 870-2091 [Phone]
 Fairfield, OH 45014

Filing Company Information

The Cincinnati Insurance Company CoCode: 10677 State of Domicile: Ohio
 6200 S. Gilmore Road Group Code: 244 Company Type:
 Fairfield, OH 45014 Group Name: State ID Number:
 (513) 870-2000 ext. [Phone] FEIN Number: 31-0542366

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Cincinnati Insurance Company	\$50.00	02/19/2008	18038586

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Llyweyia Rawlins	02/28/2008	02/28/2008

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	FORM FILING SCHEDULE	Approved	Yes
Supporting Document	MEMOFRANDUM	Approved	Yes
Form	EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION CLAIMS-MADE COVERAGE	Approved	Yes
Form	CLAIMS-MADE EMPLOYMENT PRACTICES LIABILITY COVERAGE PART DECLARATIONS	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION CLAIMS-MADE COVERAGE	GA 023 A	07 07	Application/ New Binder/Enrollment		0.00	GA023A 0707 ECLAS.pdf
Approved	CLAIMS-MADE EMPLOYMENT PRACTICES LIABILITY COVERAGE PART DECLARATIONS	GA 543	11 07	Declaration News/Schedule		0.00	GA543 11-07 ECLAS.pdf

**EMPLOYMENT PRACTICES LIABILITY INSURANCE
APPLICATION
CLAIMS-MADE COVERAGE**

**THE CINCINNATI INSURANCE COMPANY
CINCINNATI, OHIO**

Policy Number:

NOTE: COVERAGE MAY NOT BE BOUND WITHOUT PRIOR APPROVAL

POLICY INFORMATION

Applicant Name	
Primary Rating State	
Policy Effective Date	
Policy Expiration Date	
Agency Name	
Mailing Address	
Address	
Address 2	
City	
County	
State	
ZIP code	
Country	

General Information Section

Is applicant's operation For Profit or Not for Profit?	For Profit / Not for Profit
Describe the applicant's operations	
Applicant has been in business since	
Are there subsidiary companies?	Yes / No
List all subsidiary applicants to be covered and include the nature of business, percentage owned by the applicant and date acquired or created	
Total number of full-time employees (including directors and officers)	
Total number of part-time employees	
Total number of employees covered by collective bargaining agreements	
Total number of employees covered by formal employment contracts If employees under formal contract, attach copies of contracts	
Total number of salaried employees (full & part-time) covered by a formal employment contract	
Total number of hourly employees (full & part-time) covered by a formal employment contract	
Do applicants have employees located in other states or countries?	Yes / No
List of total number of employees per individual state or country	
Indicate employee turnover for the previous three years	
Number of full-time employees hired	
Number of voluntary quits	
Number of involuntary terminations	
Number of part-time employees hired	
Number of voluntary quits	
Number of involuntary terminations	

LOSS HISTORY

Has applicant had any employment lawsuits, negotiated settlements, administrative proceedings (e.g., EEOC) union grievances and internal employment practices complaints made against any applicant during the past three years? _____ Check here if none made during the past three years _____ (applicant's initials)	Yes / No
Describe the type of allegation, the court or agency involved and any determination, judgment, defense cost or settlement for each	

Are any applicants proposed for coverage aware of any facts or circumstances which: 1) may give rise to future claims that would fall within the scope of the proposed coverage, or 2) have been given as notice under the provisions of any prior or current Employment Practices Liability Insurance or similar insurance? Please list specific details	Yes / No
_____ (applicant's initials) It is agreed that if such facts or circumstances exist, whether or not disclosed, any claim arising from them is excluded from this proposed coverage	

COVERAGE REQUESTED	
Limit of Insurance	<input type="checkbox"/> \$250,000 per Wrongful Act / Aggregate <input type="checkbox"/> \$500,000 per Wrongful Act / Aggregate <input type="checkbox"/> \$1,000,000 per Wrongful Act / Aggregate
Deductible Amount	<input type="checkbox"/> \$2,500
Is Punitive Damage coverage desired? (Not available in all states)	Yes / No

EMPLOYMENT PRACTICES / PROCEDURES	
Do applicants have a Human Resources or Personnel Department?	Yes / No
Who is responsible for this function and what are that person's qualifications?	
Do applicants use legal council in establishing employment policies / procedures?	Yes / No
Do applicants use legal council in making sensitive disciplinary / termination decisions?	Yes / No
Do applicants comply with Uniform Federal Accessibility Standards?	Yes / No
Do applicants maintain employee files in a secure, locked place?	Yes / No
Do applicants securely maintain employee medical records?	Yes / No
Are they stored separately from other personal records?	Yes / No
Do applicants maintain written records of disciplinary action?	Yes / No
Do applicants conduct written performance evaluations at least annually?	Yes / No
Do applicants display, as required, federal and state mandated posters?	Yes / No
Do applicants have contracts with or receive financial assistance from the federal government?	Yes / No
List details	
Are applicants presently subject to any judicial or administrative order, decree, judgment or conciliation agreement relating to employment?	Yes / No
Please explain	
Are applicants parties to a labor leasing contract?	Yes / No
Do applicants train all supervisors on interviewing techniques not permissible under law?	Yes / No
Have any applicants filed for bankruptcy in the past five years?	Yes / No
Please explain	
Do applicants plan to acquire or merge with any companies?	Yes / No
Have applicants conducted or anticipate any layoffs, staff reductions, or facility closings?	Yes / No
Please explain	
Do applicants use polygraphs in employment procedures?	Yes / No
Do applicants use an employment application for all prospective employees?	Yes / No
Do applicants have an employee handbook?	Yes / No
Is the handbook distributed to all employees with a signed acknowledgment of receipt?	Yes / No
How often is the handbook updated?	
Do applicants have a written policy in place regarding sexual harassment policy / reporting procedure?	Yes / No

ATTACH COPIES OF APPLICANT'S	
Employment application	
Discrimination / sexual harassment policy and reporting procedures	
Employee Handbook	
Family & Medical Leave Act policy (if over 50 employees)	

UNDERSIGNED DECLARES THAT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF THE STATEMENTS SET FORTH HEREIN ARE TRUE. ALTHOUGH THE SIGNING OF THIS APPLICATION DOES NOT OBLIGATE THE UNDERSIGNED ON BEHALF OF THE APPLICANT OR ITS DIRECTORS, OFFICERS OR INSURED PERSONS TO PURCHASE INSURANCE, THE UNDERSIGNED WARRANTS THAT THIS APPLICATION AND ITS ATTACHMENTS SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND SHALL BE DEEMED ATTACHED TO AND SHALL FORM PART OF THE POLICY. WE ARE HEREBY AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION WE DEEM NECESSARY.

ANY INSPECTION, REVIEWS, REPORTS OR RECOMMENDATIONS MADE BY THE CINCINNATI INSURANCE COMPANY RELATE ONLY TO INSURABILITY AND THE PREMIUMS TO BE CHARGED. FURTHERMORE, NO RECOMMENDATIONS ARE INTENDED AS LEGAL ADVICE AND THE CINCINNATI INSURANCE COMPANY DOES NOT WARRANT THAT CONDITIONS ARE IN COMPLIANCE WITH ANY LAWS, REGULATIONS, CODES OR STANDARDS. THIS REPORT IS INTENDED SOLELY FOR INSURANCE PURPOSES.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE / SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE 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 (VT: MAY BE COMMITTING A CRIME SUBJECTING) THE PERSON TO CRIMINAL AND (NY: SUBSTANTIAL) CIVIL PENALTIES. IN THE DISTRICT OF COLUMBIA, LOUISIANA, MAINE, TENNESSEE, VIRGINIA AND WASHINGTON, INSURANCE BENEFITS MAY ALSO BE DENIED.

APPLICANT'S AUTHORIZED SIGNATURE
(of a principal, partner, officer or the director of
Human Resources / Personnel)

DATE

Print or type name shown above

TITLE

AGENT'S SIGNATURE

DATE

AGENCY AND CODE NUMBER

THE CINCINNATI INSURANCE COMPANY

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CLAIMS-MADE EMPLOYMENT PRACTICES LIABILITY COVERAGE PART DECLARATIONS

Attached to POLICY NUMBER: _____

Effective date _____

Named Insured is the same as it appears in the Package Policy Declarations unless another entry is made here.

RETROACTIVE DATE

This insurance does not apply to "wrongful acts" committed, attempted, or allegedly committed or attempted prior to the Retroactive Date shown below:

RETROACTIVE DATE _____

LIMITS OF INSURANCE

PER WRONGFUL ACT LIMIT

\$ _____

AGGREGATE LIMIT

\$ _____

DEDUCTIBLE

DEDUCTIBLE AMOUNT \$ _____

PREMIUM

TOTAL ANNUAL PREMIUM \$ _____

FORMS AND/OR ENDORSEMENTS APPLICABLE TO THIS COVERAGE PART:

This Declarations page together with the completed application(s), the Package Policy Declarations, the Employment Practices Liability Coverage Form and any accompanying endorsements shall constitute the contract between the insureds and The Cincinnati Insurance Company. The following Section III, Common Policy Conditions of the Package Policy shall also apply: A. Cancellation, B. Changes, D. Examination of Your Books and Records, E. Inspections and Surveys, I. Premiums, K. Transfer of Your Rights and Duties Under this Policy and L. Time of Inception. No other provisions of the Package Policy apply to Employment Practices Liability Coverage.

THIS INSURANCE COVERAGE CONTAINS CLAIMS-MADE COVERAGE. EXCEPT AS MAY BE OTHERWISE PROVIDED HEREIN, THIS INSURANCE IS LIMITED TO "WRONGFUL ACTS" FOR WHICH "CLAIMS" ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD. PLEASE READ AND REVIEW THIS INSURANCE CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR AGENT.

THE LIMITS OF INSURANCE AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE.

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Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty **Review Status:** Approved 02/28/2008

Comments:
PROPERTY AND CASUALTY TRANSMITTAL

Attachment:
F777AR_307[1].pdf

Satisfied -Name: FORM FILING SCHEDULE **Review Status:** Approved 02/28/2008

Comments:
FORM FILING SCHEDULE

Attachment:
F778AR_307[1].pdf

Satisfied -Name: MEMOFRANDUM **Review Status:** Approved 02/28/2008

Comments:
MEMORANDUM

Attachment:
MEMOF.pdf

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #	CBOP-08-6009-AR
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21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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See Memorandum

22. Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: EFT FILING FEE

Amount: \$50

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do **not** refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	CBOP-08-6009-AR			
2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	N/A			
3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement or Withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION CLAIMS-MADE COVERAGE	GA 023 A 07 07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	-----	-----
02	CLAIMS-MADE EMPLOYMENT PRACTICES LIABILITY COVERAGE PART DECLARATIONS	GA 543 11 07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	-----	-----
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

**ARKANSAS
BUSINESSOWNERS PACKAGE PROGRAM
FORMS MEMORANDUM**

NEW FORM	OLD FORM	TITLE/DESCRIPTION OF CHANGE
GA 023 A 07 07	-----	EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION CLAIMS-MADE COVERAGE This application is created for a new policy issuance system.
GA 543 11 07	-----	CLAIMS-MADE EMPLOYMENT PRACTICES LIABILITY COVERAGE PART DECLARATIONS Form is created for a new policy issuance system.