

SERFF Tracking Number: SELC-125710229 State: Arkansas
Filing Company: Selective Insurance Company of America State Tracking Number: EFT \$50
Company Tracking Number: 08F-GL-50AR
TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0001 Commercial General Liability
Product Name: EPLI Applications
Project Name/Number: EPLI Applications/08F-GL-50AR

Filing at a Glance

Company: Selective Insurance Company of America

Product Name: EPLI Applications

SERFF Tr Num: SELC-125710229 State: Arkansas

TOI: 17.0 Other Liability - Claims

SERFF Status: Closed

State Tr Num: EFT \$50

Made/Occurrence

Sub-TOI: 17.0001 Commercial General Liability Co Tr Num: 08F-GL-50AR

State Status: Fees verified and received

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi, Edith Roberts

Author: Tracy Potter

Disposition Date: 06/26/2008

Date Submitted: 06/26/2008

Disposition Status: Approved

Effective Date Requested (New): 10/01/2008

Effective Date (New):

Effective Date Requested (Renewal): 10/01/2008

Effective Date (Renewal):

State Filing Description:

General Information

Project Name: EPLI Applications

Status of Filing in Domicile:

Project Number: 08F-GL-50AR

Domicile Status Comments:

Reference Organization: N/A

Reference Number: N/A

Reference Title: N/A

Advisory Org. Circular: N/A

Filing Status Changed: 06/26/2008

State Status Changed: 06/26/2008

Deemer Date:

Corresponding Filing Tracking Number: N/A

Filing Description:

Please see Explanatory Memeorandum under Supporting Documentation. Thank you.

Company and Contact

Filing Contact Information

Tracy Rossman, State Filing Specialist

tracy.rossman@selective.com

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40 Wantage Ave (973) 948-1178 [Phone]
Branchville, NJ 07890 (973) 948-4538[FAX]

Filing Company Information

Selective Insurance Company of America CoCode: 12572 State of Domicile: New Jersey
40 Wantage Avenue Group Code: 242 Company Type:
Branchville, NJ 07890 Group Name: State ID Number:
(800) 777-9656 ext. [Phone] FEIN Number: 22-1272390

SERFF Tracking Number: SELC-125710229 State: Arkansas
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Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Selective Insurance Company of America	\$50.00	06/26/2008	21106260

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	06/26/2008	06/26/2008

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Disposition

Disposition Date: 06/26/2008

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SELC-125710229 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION SCHEDULE	Approved	Yes
Form	RENEWAL EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION SCHEDULE	Approved	Yes
Form	MINI EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION	Approved	Yes
Form	EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION	Approved	Yes
Form	RENEWAL EMPLOYMENT PRACTICES LIABILITY INSURANCE	Approved	Yes
Form	MINI EMPLOYMENT PRACTICES LIABILITY	Approved	Yes
Form	MINI EMPLOYMENT PRACTICES LIABILITY	Approved	Yes
Form	AMENDMENT — HANDLING OF EMPLOYMENT PRACTICES LIABILITY APPLICATION	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 SCHEDULE	EPL 99 00S	10 08	Declaration New s/Schedule		0.00	epl9900s.o08.pdf
Approved	RENEWAL EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION SCHEDULE	EPL 99 01S	10 08	Declaration New s/Schedule		0.00	epl9901s.o08.pdf
Approved	MINI EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION	EPL 99 03S	10 08	Declaration New s/Schedule		0.00	epl9903s.o08.pdf
Approved	EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION	EPL 99 00	10 08	Declaration Replaced s/Schedule	Replaced Form #:0.00 EPL 99 00 04 07 Previous Filing #: AR-PC-06-022353		epl9900.o08.pdf epl9900.407.pdf
Approved	RENEWAL EMPLOYMENT PRACTICES LIABILITY INSURANCE	EPL 99 01	10 08	Declaration Replaced s/Schedule	Replaced Form #:0.00 EPL 99 01 04 07 Previous Filing #: AR-PC-06-022353		epl9901.o08.pdf epl9901.407.pdf
Approved	MINI EMPLOYMENT PRACTICES LIABILITY	EPL 99 02	10 08	Declaration Replaced s/Schedule	Replaced Form #:0.00 EPL 99 02 04 07 Previous Filing #: AR-PC-06-		epl9902.o08.pdf EPL9902.407.pdf

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 TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0001 Commercial General Liability
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022353

Approved	MINI EMPLOYMENT PRACTICES LIABILITY	EPL 99 03 10 08	Declaration Replaced s/Schedule	Replaced Form #:0.00 EPL 99 03 04 07 Previous Filing #: AR-PC-06- 022353	0.00	epl9903.o08. pdf epl9903 407.pdf
Approved	AMENDMENT — HANDLING OF EMPLOYMENT PRACTICES LIABILITY APPLICATION	EPL 60 03 10 08	Endorseme New nt/Amendm ent/Condi ons		0.00	EPL6003.o0 8.pdf

RENEWAL EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION SCHEDULE

EMPLOYMENT PRACTICES LIABILITY
EPL 99 01S 10 08

II. EMPLOYEES — (Continued)

2. Total number of employees and independent contractors for the expiring and next year:

Expiring Year						Next Year					
State	Number of Locations by State	Employees				State	Number of Locations by State	Employees			
		# FT	# PT*	# TL	# IC**			# FT	# PT*	# TL	# IC**

* 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 Insurance Application.

MINI EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION

EMPLOYMENT PRACTICES LIABILITY
EPL 99 03S 10 08

EMPLOYEES — (Continued)

Number of Employees (if more than two locations, also provide this information for the additional locations)

	Location (List City, State)			Location (List City, State)		
	This Year	Prior Year	2 nd Prior	This Year	Prior Year	2 nd Prior
Full-Time Employees	_____	_____	_____	_____	_____	_____
*Part-Time Employees	_____	_____	_____	_____	_____	_____
Temporary Employees	_____	_____	_____	_____	_____	_____
Leased Workers	_____	_____	_____	_____	_____	_____
**Independent Contractors	_____	_____	_____	_____	_____	_____

	Location (List City, State)			Location (List City, State)		
	This Year	Prior Year	2 nd Prior	This Year	Prior Year	2 nd Prior
Full-Time Employees	_____	_____	_____	_____	_____	_____
*Part-Time Employees	_____	_____	_____	_____	_____	_____
Temporary Employees	_____	_____	_____	_____	_____	_____
Leased Workers	_____	_____	_____	_____	_____	_____
**Independent Contractors	_____	_____	_____	_____	_____	_____

	Location (List City, State)			Location (List City, State)		
	This Year	Prior Year	2 nd Prior	This Year	Prior Year	2 nd Prior
Full-Time Employees	_____	_____	_____	_____	_____	_____
*Part-Time Employees	_____	_____	_____	_____	_____	_____
Temporary Employees	_____	_____	_____	_____	_____	_____
Leased Workers	_____	_____	_____	_____	_____	_____
**Independent Contractors	_____	_____	_____	_____	_____	_____

* 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 Insurance Application.

5. Total number of employees and other workers for each of the last three years, all states combined:

	Current Year	Previous Year	2 Years Ago
Full Time Employees:	_____	_____	_____
*Part Time Employees:	_____	_____	_____
Temporary/Leased workers:	_____	_____	_____
**Independent Contractors:	_____	_____	_____

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

** Independent Contractors are not covered as insureds, but they can be claimants, so their use must be reported. If you desire coverage as an insured, please use the Supplemental Insurance Application.

6. Percent of workforce that are union members:

Current Year: _____ Previous Year: _____ 2 Years Ago: _____

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	_____	_____

8. a. 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 acquisitions the past 24 months?

Yes No

If yes, provide details on the Supplemental Insurance Application.

b. Do you anticipate any of the above within the next 12 months?

Yes No

If yes, provide details on the Supplemental Insurance Application.

9. Total number of employer-initiated terminations of Full-Time and Part-Time employees (Involuntary Turnover):

Current Year: _____ Last Year: _____ 2 Years Ago: _____

10. Number of Full Time and Part Time employees terminating employment during the year divided by the total at the start of the year (Voluntary Turnover):

Current Year: _____% Last Year: _____% 2 Years Ago: _____%

III. LOSS HISTORY

11. Within the last five years, has the company 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?

Yes No

b. Had a claim, suit, grievance, or demand brought against them?

Yes No

If yes to either, please provide details on the Supplemental Insurance Application.

12. Are you aware of any facts, incidents, or circumstances that may result in a claim(s) being made against you? Yes No

If yes, provide details on the Supplemental Insurance Application.

THE APPLICANT UNDERSTANDS AND AGREES THAT IF ANY FACTS, INCIDENTS, OR CIRCUMSTANCES EXIST 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

13. 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 _____

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

a. Psychological or personality tests?: Yes No

b. Drug or alcohol tests?: Yes No

c. Pre-employment offer medical tests?: Yes No

If yes, provide details on the Supplemental Insurance Application.

V. INSURANCE INFORMATION

15. Do you currently carry EPLI? Yes No
If yes, please provide:

Insurer: _____ Limit: _____ (per claim/aggregate)
Policy Period: _____ Retroactive Date: _____
Deductible: _____ Co-Insurance Amount: _____
Premium: _____

16. Current EPLI coverage, if any, has been continuous since _____

If not continuous, provide details on the Supplemental Insurance Application.

17. Current GL carrier? _____ Limit of liability? _____

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

- \$100,000/\$100,000 \$250,000/\$250,000 \$500,000/\$500,000
- \$1,000,000/\$1,000,000 \$2,000,000/\$2,000,000

19. Deductible (per claim) — Check desired amount:

- \$5,000 \$10,000 \$15,000 \$20,000 \$25,000

VI. RISK MANAGEMENT PRACTICES

- 20. a.** Have all your employment-related policies and procedures been reviewed and approved by outside counsel? Yes No
If yes, when? _____
By whom? Firm: _____
Attorney: _____
- b.** Have all recommendations from that review been implemented? Yes No
If no, explain or provide timeframe for implementation on the Supplemental Insurance Application.
- 21.** Do you use an employment application during your hiring process? Yes No
If yes, does it contain:
- a.** An employment-at-will statement? Yes No
- b.** Authorization to check references and criminal conviction records? Yes No
- c.** The applicant's signature attesting that all representations are true? Yes No
- d.** An equal employment opportunity statement? Yes No
- 22.** Do you distribute an Employee Handbook to your employees? Yes No
If yes, does it contain:
- a.** An employment-at-will statement? Yes No
- b.** A written equal employment opportunity statement? Yes No
- c.** A written sexual harassment and other harassment policies? Yes No
- d.** A written internal complaint procedure for discrimination and sexual harassment claims? Yes No
- If no, do you have written policies on all of the above that are distributed separately? Yes No
Specify any that are not.
- 23.** Do you have a progressive disciplinary program? Yes No
If yes, has it been distributed to supervisors in writing? Yes No
- 24.** Do you post, in places conspicuous to all employees and applicants for employment, all notices required by law? Yes No
- 25.** When requested by employees, do you distribute information as required by federal law regarding the Family Medical Leave Act? Yes No
- 26.** Do you require that all employment terminations be reviewed by the personnel having human resources responsibilities? Yes No
- 27.** Have you informed supervisory personnel, in writing, of their responsibility to provide you with prompt notice of any claims, incidents or allegations? Yes No

28. Do you provide training to your employees on any of the following employment practice topics?

- | | | |
|-------------------------------------|------------------------------|-----------------------------|
| > Sexual Harassment | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| > Discrimination | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| > Americans with Disabilities Act | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| > Family Medical Leave Act | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| > Reporting Incidents of Complaints | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

II. ADDITIONAL INFORMATION - Please attach each of the following, if they exist:

- 3 Employee Handbook
- 3 Employee grievance, disciplinary, termination and out-placement procedures
- 3 Employment Application Form(s)
- 3 Equal Employment Opportunity and Discrimination and Sexual Harassment Policy, Discrimination and Sexual Harassment Policy
- 3 Separation Agreement Form

FRAUD WARNING

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.

APPLICABLE IN ARKANSAS

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

APPLICABLE IN DISTRICT OF COLUMBIA, MAINE AND VIRGINIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 civil penalties. In the District of Columbia, Maine and Virginia, insurance benefits may also be denied.

APPLICABLE 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.

APPLICABLE IN KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

APPLICABLE IN MICHIGAN

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information, shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000.00.

APPLICABLE IN MINNESOTA

Any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN NEW YORK

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 violation.

APPLICABLE IN OHIO

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.

APPLICABLE IN 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 the person to criminal and civil penalties.

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 INSURED 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 THAT 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.

Signatures of:

President or Chairman: _____

Dated: _____

Individual responsible for
Human Resources function: _____

Dated: _____

Insurance Agent: _____

Dated: _____

EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION

EMPLOYMENT PRACTICES LIABILITY
EPL 99 00 04 07

I. CORPORATE HISTORY

1. Describe the firm's operations:

2. Number of years in business? _____

3. Does the organization have any contracts with or receive financial assistance from the from the Federal Government or any agency thereof? Yes No

If yes, provide details on the Supplemental Insurance Application.

II. EMPLOYEES

4. a. 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 three years:

Current Year					Prior Year					2 Years Ago									
State	Number of Locations by State	Employees				State	Number of Locations by State	Employees				State	Number of Locations by State	Employees					
		# FT	# PT	# TL	# IC			# FT	# PT	# TL	# IC			# FT	# PT	# TL	# IC		

* Defined as employees working less than 32 hours per week/1600 hours per year.
 ** Independent Contractors are not covered as insured, but they can be claimants under the basic policy, so their use must be reported. If you desire coverage as an insured, please use the Supplemental Insurance Application.

b. If you wish to include coverage by endorsement for Independent Contractors, please indicate by answering "Yes." Yes No

5. Total number of employees and other workers for each of the last three years, all states combined:

	Current Year	Previous Year	2 Years Ago
Full Time Employees:	_____	_____	_____
*Part Time Employees:	_____	_____	_____
Temporary/Leased workers:	_____	_____	_____
**Independent Contractors:	_____	_____	_____
	_____%	_____%	_____%

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

** Independent Contractors are not covered as insureds, but they can be claimants, so their use must be reported. If you desire coverage as an insured, please use the Supplemental Insurance Application.

6. Percent of workforce that are union members:

Current Year: _____ Previous Year: _____ 2 Years Ago: _____

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	_____	_____

8. a. 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?

Yes No

If yes, provide details on the Supplemental Insurance Application.

b. Do you anticipate any of the above within the next 12 months?

Yes No

If yes, provide details on the Supplemental Insurance Application.

9. Total number of employer-initiated terminations of Full-Time and Part-Time employees (Involuntary Turnover):

Current Year: _____ Last Year: _____ 2 Years Ago: _____

10. Number of Full Time and Part Time employees terminating employment during the year divided by the total at the start of the year (Voluntary Turnover):

Current Year: _____% Last Year: _____% 2 Years Ago: _____%

III. LOSS HISTORY

11. Within the last five years, has the company 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? Yes No

b. Had a claim, suit, grievance, or demand brought against them? Yes No

If yes to either, please provide details on the Supplemental Insurance Application.

12. Are you aware of any facts, incidents, or circumstances that may result in a claim(s) being made against you? Yes No

If yes, provide details on the Supplemental Insurance Application.

THE APPLICANT UNDERSTANDS AND AGREES THAT IF ANY FACTS, INCIDENTS, OR CIRCUMSTANCES EXIST 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

13. 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 _____

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

a. Psychological or personality tests? Yes No

b. Drug or alcohol tests? Yes No

c. Pre-employment offer medical tests? Yes No

If yes, provide details on the Supplemental Insurance Application.

V. INSURANCE INFORMATION

15. Do you currently carry EPLI? Yes No

If yes, please provide:

Insurer: _____

Limit: _____ (per claim/aggregate)

Policy Period: _____

Retroactive Date: _____

Deductible: _____

Co-Insurance Amount: _____

Premium: _____

16. Has any insurer ever canceled or non-renewed this type of coverage? Yes No

If yes, provide details on the Supplemental Insurance Application.

17. Current GL carrier? _____ Limit of liability? _____

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

\$100,000/\$100,000 \$250,000/\$250,000 \$500,000/\$500,000
 \$1,000,000/\$1,000,000 \$2,000,000/\$2,000,000

19. Deductible (per claim) — Check desired amount:

- \$5,000 \$10,000 \$15,000 \$20,000 \$25,000

VI. RISK MANAGEMENT PRACTICES

20. a. Have all your employment-related policies and procedures been reviewed and approved by outside counsel? Yes No
If yes, when? _____
By whom? Firm: _____
Attorney: _____
- b. Have all recommendations from that review been implemented? Yes No
If no, explain or provide timeframe for implementation on the Supplemental Insurance Application.
21. Do you use an employment application during your hiring process? Yes No
If yes, does it contain:
- a. An employment-at-will statement? Yes No
- b. Authorization to check references and criminal conviction records? Yes No
- c. The applicant's signature attesting that all representations are true? Yes No
- d. An equal employment opportunity statement? Yes No
22. Do you distribute an Employee Handbook to your employees? Yes No
If yes, does it contain:
- a. An employment-at-will statement? Yes No
- b. A written equal employment opportunity statement? Yes No
- c. A written sexual harassment and other harassment policies? Yes No
- d. A written internal complaint procedure for discrimination and sexual harassment claims? Yes No
- If no, do you have written policies on all of the above that are distributed separately? Yes No
Specify any that are not.
23. Do you have a progressive disciplinary program? Yes No
If yes, has it been distributed to supervisors in writing? Yes No
24. Do you post, in places conspicuous to all employees and applicants for employment, all notices required by law? Yes No

25. When requested by employees, do you distribute information as required by federal law regarding the Family Medical Leave Act? Yes No
26. Do you require that all employment terminations be reviewed by the personnel having human resources responsibilities? Yes No
27. Have you informed supervisory personnel, in writing, of their responsibility to provide you with prompt notice of any claims, incidents or allegations? Yes No
28. Do you provide training to your employees on any of the following employment practice topics?
- > Sexual Harassment Yes No
 - > Discrimination Yes No
 - > Americans with Disabilities Act Yes No
 - > Family Medical Leave Act Yes No
 - > Reporting Incidents of Complaints Yes No

II. 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)
- Equal Employment Opportunity and Discrimination and Sexual Harassment Policy, Discrimination and Sexual Harassment Policy
- Separation Agreement Form

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 INSURED 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 THAT 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.

Signatures of:

President or Chairman: _____

Dated: _____

Individual responsible for Human Resources function: _____

Dated: _____

RENEWAL EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION

EMPLOYMENT PRACTICES LIABILITY
EPL 99 01 10 08

I. CORPORATE HISTORY

1. Provide details of any changes in the firm's operations in the past year, including mergers/acquisitions, downsizing/layoffs (greater than 10% at any location), new contracts with the Federal Government, or Union participation.

II. EMPLOYEES

2. Total number of employees and independent contractors for the expiring and next year:

Expiring Year					Next Year							
State	Number of Locations by State	Employees				State	Number of Locations by State	Employees				
		# FT	# PT*	# TL	# IC**			# FT	# PT*	# TL	# IC**	

* 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 Insurance Application.

3. Breakdown of current Full Time employees by their total cash compensation:

Salary Ranges	# of Employees	% of total
\$30,000 or less per year	_____	_____
\$30,001-\$100,000 per year	_____	_____
Over \$100,000 per year	_____	_____

- 4. Number of Full Time and Part Time employees terminating employment divided by the total at the start of the year (Turnover) for the last year: _____%
- 5. Total number of employer-initiated terminations of Full Time and Part Time employees in the last year:

III. LOSS HISTORY

- 6. Within the last year, 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? Yes No
 - b. Had a claim, suit, grievance, or demand been brought against them? Yes No

If yes, to either, explain any that has not previously been reported to us.
 - 7. Are you aware of any facts, incidents, or circumstances that may result in a claim(s) being made against you? Yes No
- If yes, explain.

FAILURE TO DISCLOSE SUCH KNOWN FACTS, INCIDENTS OR CIRCUMSTANCES HERE WILL VOID THE RE-NEWED POLICY IN ITS ENTIRETY.

IV. HUMAN RESOURCES FUNCTION

- 8. 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 _____
- 9. Have you made any changes to your use of any of the following tests to screen employment applicants, to promote employees, or for the purpose of continuing employment? Yes No
 - a. Psychological or personality tests: Yes No
 - b. Drug or alcohol tests: Yes No
 - c. Pre-employment offer medical tests: Yes No

If yes, provide details of test used, how administered and validation documentation.

V. INSURANCE INFORMATION

10. Current GL carrier? _____
Limit of liability _____

11. Do you desire any changes to:

a. Limits of liability (per claim / aggregate):

- \$100,000/\$100,000 \$250,000/\$250,000 \$500,000/\$500,000
 \$1,000,000/\$1,000,000 \$2,000,000/\$2,000,000

b. Deductible (per claim) — Check desired amount:

- \$5,000 \$10,000 \$15,000 \$20,000 \$25,000

VI. RISK MANAGEMENT PRACTICES

12. a. Have all your employment-related policies and procedures been reviewed and approved by outside counsel in the past year? Yes No
If yes, when? _____
By whom? Firm: _____
Attorney: _____

b. Have all recommendations from that review been implemented? Yes No
If not, explain reason or provide timeframe for implementation.

13. Have you made any changes to your use of, or the content of:

- a. An employment application? Yes No
- b. An employment-at-will statement? Yes No
- c. Authorization to check references and criminal conviction records? Yes No
- d. Signature by job applicants attesting all representations are true? Yes No
- e. An equal employee opportunity statement? Yes No
- f. An employment handbook? Yes No
- g. A written sexual harassment or other harassment policy? Yes No
- h. Written internal complaint procedure for discrimination and harassment claims? Yes No
- i. A progressive disciplinary program? Yes No
- j. Posting in places conspicuous to all employees and applicants for employment, all notices required by law? Yes No
- k. Distribution of information as required by federal law regarding the Family Medical Leave Act? Yes No

14. Do you require that all employment terminations be reviewed by the personnel having human resources responsibilities? Yes No

15. Have you informed supervisory personnel in the past year, in writing, of their responsibility to provide you with prompt notice of any claims, incidents or allegations? Yes No

VII. ADDITIONAL INFORMATION

Please attach each of the following, if they have been created or amended in the past year:

- 3 Employee Handbook
- 3 Employee grievance, disciplinary, termination and out-placement procedures
- 3 Employment Application Form(s)
- 3 Equal Employment Opportunity and Discrimination and Sexual Harassment Policy
- 3 Separation Agreement Form

FRAUD WARNING

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.

APPLICABLE IN ARKANSAS

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

APPLICABLE IN DISTRICT OF COLUMBIA, MAINE AND VIRGINIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 civil penalties. In the District of Columbia, Maine and Virginia, insurance benefits may also be denied.

APPLICABLE 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.

APPLICABLE IN KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

APPLICABLE IN MICHIGAN

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information, shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000,00.

APPLICABLE IN MINNESOTA

Any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN NEW YORK

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 violation.

APPLICABLE IN OHIO

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.

APPLICABLE IN 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 the person to criminal and civil penalties.

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. 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.

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 INSURED MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

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President or Chairman: _____ Dated: _____

Individual responsible for
Human Resources function: _____ Dated: _____

Insurance Agent: _____ Dated: _____

RENEWAL EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION

EMPLOYMENT PRACTICES LIABILITY
EPL 99 01 04 07

I. CORPORATE HISTORY

- Provide details of any changes in the firm's operations in the past year, including mergers/acquisitions, downsizing/layoffs (greater than 10% at any location), new contracts with the Federal Government, or Union participation.

II. EMPLOYEES

- Total number of employees and independent contractors for the expiring and next year:

Expiring Year					Next Year								
State	Number of Locations by State	Employees				State	Number of Locations by State	Employees					
		# FT	# PT*	# TL	# IC**			# FT	# PT*	# TL	# IC**		

* 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 Insurance Application.

- Breakdown of current Full Time employees by their total cash compensation:

<u>Salary Ranges</u>	<u># of Employees</u>	<u>% of total</u>
\$30,000 or less per year	_____	_____
\$30,001–\$100,000 per year	_____	_____
Over \$100,000 per year	_____	_____

- Number of Full Time and Part Time employees terminating employment divided by the total at the start of the year (Turnover) for the last year: _____%
- Total number of employer-initiated terminations of Full Time and Part Time employees in the last year: _____

III. LOSS HISTORY

- Within the last year, has the firm, inclusive of predecessor firms, or any individual proposed for this insurance:
 - Received any employment-related inquiry, complaint or charge from any municipal, state, or federal regulatory authority or any other governmental entity? Yes No
 - Had a claim, suit, grievance, or demand been brought against them? Yes No
If yes to either, explain any that has not previously been reported to us.

7. Are you aware of any facts, incidents, or circumstances that may result in a claim(s) being made against you? Yes No

If yes, explain.

FAILURE TO DISCLOSE SUCH KNOWN FACTS, INCIDENTS OR CIRCUMSTANCES HERE WILL VOID THE RENEWED POLICY IN ITS ENTIRETY.

IV. HUMAN RESOURCES FUNCTION

8. 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 _____
9. Have you made any changes to your use of any of the following tests to screen employment applicants, to promote employees, or for the purpose of continuing employment? Yes No
- a. Psychological or personality tests: Yes No
- b. Drug or alcohol tests: Yes No
- c. Pre-employment offer medical tests: Yes No

If yes, provide details of test used, how administered and validation documentation.

V. INSURANCE INFORMATION

10. Current GL carrier? _____
Limit of liability _____

11. Do you desire any changes to:

a. Limits of liability (per claim / aggregate):

- \$100,000/\$100,000 \$250,000/\$250,000 \$500,000/\$500,000
 \$1,000,000/\$1,000,000 \$2,000,000/\$2,000,000

b. Deductible (per claim) — Check desired amount:

- \$5,000 \$10,000 \$15,000 \$20,000 \$25,000

VI. RISK MANAGEMENT PRACTICES

12. a. Have all your employment-related policies and procedures been reviewed and approved by outside counsel in the past year? Yes No

If yes, when? _____

By whom? Firm: _____ Attorney: _____

- b. Have all recommendations from that review been implemented? Yes No
If not, explain reason or provide timeframe for implementation.

13. Have you made any changes to your use of, or the content of :

- a. an employment application? Yes No
 - b. an employment-at-will statement? Yes No
 - c. authorization to check references and criminal conviction records? Yes No
 - d. signature by job applicants attesting all representations are true? Yes No
 - e. an equal employee opportunity statement? Yes No
 - f. an employment handbook? Yes No
 - g. a written sexual harassment or other harassment policy? Yes No
 - h. written internal complaint procedure for discrimination and harassment claims? Yes No
 - i. a progressive disciplinary program? Yes No
 - j. posting in places conspicuous to all employees and applicants for employment, all notices required by law? Yes No
 - k. distribution of information as required by federal law regarding the Family Medical Leave Act? Yes No
14. Do you require that all employment terminations be reviewed by the personnel having human resources responsibilities? Yes No
15. Have you informed supervisory personnel in the past year, in writing, of their responsibility to provide you with prompt notice of any claims, incidents or allegations? Yes No

VII. ADDITIONAL INFORMATION

Please attach each of the following, *if they have been created or amended in the past year:*

- Employee Handbook
- Employee grievance, disciplinary, termination, and out-placement procedures
- Employment Application Form(s)
- Equal Employment Opportunity and Discrimination and Sexual Harassment Policy
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President or Chairman: _____ Dated: _____

Individual responsible for
Human Resources function: _____ Dated: _____

Withdrawal

SUPPLEMENTAL INSURANCE APPLICATION

EMPLOYMENT PRACTICES LIABILITY
EPL 99 02 10 08

To be completed by any applicant with "Yes" responses to questions 3., 4., 5., 8., 11., 12., 14., 16. or 20. on the standard insurance application, or with interest in coverage for Independent Contractors.

3. Description of contracts with Federal Government, including revenue size and any financial assistance:

Is there an affirmative action plan?

YES NO

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

4-5. 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 onsite or offsite.

8. a. Details of plant, facility or branch office closings, consolidations, layoffs/staff reductions (greater than 10% of the workforce), mergers or acquisitions within the past 24 months:

b. Details on any of the above anticipated in the next 12 months:

11. 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 five 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 five years: (Provide date, complete description, amount demanded, and amount paid and/or reserved.)

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

14. 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.

16. History of Employment Practices Liability Insurance:

Carrier: _____ Effective Date: _____

Carrier: _____ Effective Date: _____

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

FRAUD WARNING

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.

APPLICABLE IN ARKANSAS

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

APPLICABLE IN DISTRICT OF COLUMBIA, MAINE AND VIRGINIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 civil penalties. In the District of Columbia, Maine and Virginia, insurance benefits may also be denied.

APPLICABLE 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.

APPLICABLE IN KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

APPLICABLE IN MICHIGAN

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information, shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000,00.

APPLICABLE IN MINNESOTA

Any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN NEW YORK

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 violation.

APPLICABLE IN OHIO

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.

APPLICABLE IN 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 the person to criminal and civil penalties.

Insurance Agent: _____ Dated: _____

SUPPLEMENTAL INSURANCE APPLICATION

EMPLOYMENT PRACTICES LIABILITY
EPL 99 02 04 07

To be completed by any applicant with "Yes" responses to questions **3, 4, 5, 8, 11, 12, 14, 16** or **20** on the standard insurance application, or with interest in coverage for Independent Contractors.

3. Description of contracts with 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.

- 4-5.** 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 onsite or offsite.
- 8. a.** Details of plant, facility or branch office closings, consolidations, layoffs/staff reductions (greater than 10% of the workforce), mergers or acquisitions within the past 24 months:
- b.** Details on any of the above anticipated in the next 12 months:
- 11. 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 five 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 five years: (Provide date, complete description, amount demanded, and amount paid and/or reserved.)
- 12.** Details of any facts, incidents, or circumstances which may result in a claim(s) being made against you.
- 14.** 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.
- 16.** Details of canceled Employment Practices Liability Insurance:
- Carrier: _____ Cancellation Date: _____
- Reason: _____
- 20.** Explain any recommendations made by outside counsel that have not been implemented, and reason why or timeframe to complete.

EMPLOYEES

Number of Employees (if more than two locations, also provide this information for the additional locations)

	Location 1 (List City, State)			Location 2 (List City, State)		
	This Year	Prior Year	2 nd Prior	This Year	Prior Year	2 nd Prior
Full-Time Employees	_____	_____	_____	_____	_____	_____
Part-Time Employees	_____	_____	_____	_____	_____	_____
Temporary Employees	_____	_____	_____	_____	_____	_____
Leased Workers	_____	_____	_____	_____	_____	_____
Independent Contractors	_____	_____	_____	_____	_____	_____

Percentage of employees that are: Salaried _____% Non-Salaried _____%

Percentage of employees who are union members this year: _____%

Percentage of employees by salary range:

Less than \$30,000	_____%
\$30,000 to \$100,000	_____%
over \$100,000	_____%

	This Year	Prior Year
	2 nd Prior	
What was your employee turnover rate for the last 3 years?	_____%	_____%
	_____%	

What percent of terminations were employer-initiated for the last 3 years?	_____%	_____%
	_____%	

PRIOR YEAR HISTORY

Have you had any office, branch, facility or plant closings, consolidations, layoffs or staff reductions (greater than 10% of the workforce), mergers or acquisitions within the last 12 months? Yes No

If yes, please describe:

Do you anticipate any office, branch, facility or plant closings, consolidations, layoffs or staff reductions (greater than 10% of the workforce), mergers or acquisitions within the next 12 months? Yes No

If yes, please describe:

RISK MANAGEMENT PRACTICES

Do you use an employment application during your hiring process?
If yes, please attach. Yes No

Do you have a written anti-harassment or discrimination policy?
If yes, please attach. Yes No

Do you have a written equal opportunity statement?
If yes, please attach. Yes No

Do you have a written internal complaint and progressive disciplinary
procedure for discrimination and harassment claims?
If yes, please attach copies of both. Yes No

Do you post in places conspicuous to all employees and applicants for
employment all notices required by law? Yes No

Have your employment policies and procedures been reviewed and
approved by outside counsel? Yes No

LOSS HISTORY

Has the firm received any employment-related lawsuits, negotiated settlements, grievances, EEOC or other ad-
ministrative proceedings from any municipal, state or federal regulatory authorities or any other government entities?
If yes, please attach details. If none, write {none} here. _____

Are you aware of any facts or circumstances, which you reasonably believe, may result in employment-related
practices claims being made against the applicant? **If yes, please attach details. If none, write {none} here.**

FRAUD WARNING

**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.**

APPLICABLE IN ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or
knowingly presents false information in an application for insurance, is guilty of a crime and may be
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APPLICABLE IN DISTRICT OF COLUMBIA, MAINE AND VIRGINIA

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application for insurance containing any materially false information, or conceals for the purpose of
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claim or an application containing any false, incomplete, or misleading information, is guilty of a felony of
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Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information, shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000,00.

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APPLICABLE IN NEW YORK

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 violation.

APPLICABLE IN OHIO

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.

APPLICABLE IN 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 the person to criminal and civil penalties.

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 civil penalties.

The applicant understands and agrees that this application, original application, and any supplements thereto are part of the policy, and any successive renewals that may be issued, and that the Insurance Company relies on the truth of the statements set forth herein in making a determination to issue any policy.

The applicant represents to the best of his or her knowledge and belief that the statements set forth herein are true and include all material information. The applicant further represents that if the information supplied on this application changes between the date of the application and the inception date of the policy period, the applicant will notify the Insurance Company of such change. 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.

The signing of this application does not bind the applicant to accept any insurance offered, nor does the signing of the application bind the insurance company to renew an insurance policy.

	SIGNATURE	DATE (MM/DD/YY)
APPLICANT~S Proprietor, Partner, or Officer	_____	_____
APPLICANT~S HR Representative	_____	_____
INSURANCE AGENT	_____	_____

MINI EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION

EMPLOYMENT PRACTICES LIABILITY
EPL 99 03 04 07

This is a claims-made policy. Defense costs reduce the Limit of Insurance.

APPLICANT INFORMATION

Name and Address:

Effective Date: ____/____/____

Business Type

- a. Individual Corporation Limited Liability Company Partnership
 Joint Venture Other _____
- b. Franchised Operation Non-Franchised Operation

Number of Years in Business: _____ SIC Code: _____

Describe the business operation: _____

COVERAGE INFORMATION

Limits Requested (per claim/aggregate)

- \$100,000/\$100,000 \$250,000/\$250,000 \$500,000/\$500,000 \$1,000,000/\$1,000,000
 \$2,000,000/\$2,000,000

Deductible Requested: _____

- \$5,000 \$10,000 \$15,000 \$20,000 \$25,000

Prior Coverage Information:

Prior Insurance Coverage? Yes No

Limit: _____

Carrier: _____

If yes, was prior coverage canceled or non-renewed? Yes No

Retro Date: _____

EMPLOYEES

Number of Employees (if more than two locations, also provide this information for the additional locations)

	Location 1 (List City, State)			Location 2 (List City, State)		
	This Year	Prior Year	2 nd Prior	This Year	Prior Year	2 nd Prior
Full-Time Employees	_____	_____	_____	_____	_____	_____
Part-Time Employees	_____	_____	_____	_____	_____	_____
Temporary Employees	_____	_____	_____	_____	_____	_____
Leased Workers	_____	_____	_____	_____	_____	_____
Independent Contractors	_____	_____	_____	_____	_____	_____

Percentage of employees that are: Salaried _____% Non-Salaried _____%

Percentage of employees who are union members this year: _____%

Percentage of employees by salary range: Less than \$30,000 _____%
 \$30,000 to \$100,000 _____%
 over \$100,000 _____%

What was your employee turnover rate for the last 3 years?
 _____% This Year
 _____% 2nd Prior
 _____% Prior Year

What percent of terminations were employer-initiated for the last 3 years?
 _____% This Year
 _____% 2nd Prior
 _____% Prior Year

PRIOR YEAR HISTORY

Have you had any office, branch, facility or plant closings, consolidations, layoffs or staff reductions (greater than 10% of the workforce), mergers or acquisitions within the last 12 months? Yes No

If yes, please describe:

Do you anticipate any office, branch, facility or plant closings, consolidations, layoffs or staff reductions (greater than 10% of the workforce), mergers or acquisitions within the next 12 months? Yes No

If yes, please describe:

RISK MANAGEMENT PRACTICES

Do you use an employment application during your hiring process? Yes No
 If yes, please attach.

Do you have a written anti-harassment or discrimination policy? Yes No
 If yes, please attach.

Do you have a written equal opportunity statement? Yes No
 If yes, please attach.

Do you have a written internal complaint and progressive disciplinary procedure for discrimination and harassment claims? Yes No
If yes, please attach copies of both.

Do you post in places conspicuous to all employees and applicants for employment all notices required by law? Yes No

Have your employment policies and procedures been reviewed and approved by outside counsel? Yes No

LOSS HISTORY

Has the firm received any employment-related lawsuits, negotiated settlements, grievances, EEOC or other administrative proceedings from any municipal, state or federal regulatory authorities or any other government entities? **If yes, please attach details. If none, write "none" here.** _____

Are you aware of any facts or circumstances, which you reasonably believe, may result in employment-related practices claims being made against the applicant? If yes, please attach details. **If none, write "none" here.** _____

The applicant understands and agrees that this application, original application, and any supplements thereto are part of the policy, and any successive renewals that may be issued, and that the Insurance Company relies on the truth of the statements set forth herein in making a determination to issue any policy.

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The signing of this application does not bind the applicant to accept any insurance offered, nor does the signing of the application bind the insurance company to renew an insurance policy.

SIGNATURE

DATE (MM/DD/YY)

APPLICANT'S Proprietor, Partner, or Officer _____

APPLICANT'S HR Representative _____

AGENT _____

AMENDMENT — HANDLING OF EMPLOYMENT PRACTICES LIABILITY APPLICATION

EMPLOYMENT PRACTICES LIABILITY
EPL 60 03 10 08

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

EMPLOYMENT PRACTICES LIABILITY INSURANCE

You have completed an application and it is on file with the company and incorporated by reference to the policy herein. You may request a copy of the original signed application directly from us or your insurance agent.

SERFF Tracking Number: *SELC-125710229* *State:* *Arkansas*
Filing Company: *Selective Insurance Company of America* *State Tracking Number:* *EFT \$50*
Company Tracking Number: *08F-GL-50AR*
TOI: *17.0 Other Liability - Claims Made/Occurrence* *Sub-TOI:* *17.0001 Commercial General Liability*
Product Name: *EPLI Applications*
Project Name/Number: *EPLI Applications/08F-GL-50AR*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: SELC-125710229 State: Arkansas
Filing Company: Selective Insurance Company of America State Tracking Number: EFT \$50
Company Tracking Number: 08F-GL-50AR
TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0001 Commercial General Liability
Product Name: EPLI Applications
Project Name/Number: EPLI Applications/08F-GL-50AR

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty

Review Status: Approved 06/26/2008

Comments:

Attachment:

NAIC Transmittal 3-07.pdf

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

3. Group Name	Group NAIC #
Selective Insurance Group	242

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Selective Insurance Company of America	NJ	12572	22-1272390	

5. Company Tracking Number	08F-GL-50AR
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Tracy Potter (Rossman)	State Filing Specialist	800-777-9656 x 1178	973-948-4538	tracy.potter@selective.com

7. Signature of authorized filer	
8. Please print name of authorized filer	Tracy Potter (Rossman)

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	Other Liability - Claims Made/Occurrence
10. Sub-Type of Insurance (Sub-TOI)	Commercial General Liability
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: 10-01-2008 Renewal: 10-01-2008

Property & Casualty Transmittal Document---

15.	Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16.	Reference Organization (if applicable)	N/A
17.	Reference Organization # & Title	N/A
18.	Company's Date of Filing	6-26-2008
19.	Status of filing in domicile	<input type="checkbox"/> Not Filed <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

20.	This filing transmittal is part of Company Tracking #	08F-GL-50AR
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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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Selective Insurance Company of America proposes to revise and withdraw multiple forms pertaining to our Employment Practices Liability Application program. Please see Explanatory Memorandum for comprehensive detail.

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]
<p>Check #: EFT Amount: \$50.00 \$50.00 per form filing.</p> <p>Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.</p>	

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