OREGON MUTUAL INSURANCE COMPANY
EMPLOYMENT PRACTICES LIABILITY INSURANCE
APPLICATION

EFFECTIVE DATE: ______________________

APPLICANT INFORMATION (*Name and Address*)

____
____
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____
____

AGENCY

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FORM OF BUSINESS

☐ Individual ☐ Limited Liability Company ☐ Partnership ☐ Joint Venture
☐ Organization (Other than Limited Liability Company, Partnership or Joint Venture)

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 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 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					
		Employees						Employees						Employees			
State	Number of Locations by State	# FT	# PT	# TL	# IC	State	Number of Locations by State	# FT	# PT	# TL	# IC	State	Number of Locations by State	# 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 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.*

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 last 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 government 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 insured ever cancelled 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):

   ☐ $250,000/$250,000 ☐ $500,000/$500,000 ☐ $1,000,000/$1,000,000 ☐ Other

19. Check desired:
   a. Deductible (per claim):
   ☐ $5,000 (min.) ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000

   b. Co-insurance retention* (per claim) (where available): ☐ 0% ☐ 5% ☐ 10%

   * This co-insurance retention by you may be subject to a dollar limitation as low as $25,000. Check with the company for details.

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? *Specify any that are not.* ☐ Yes ☐ No

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 Complaint ☐ Yes ☐ No

II. <u>ADDITIONAL INFORMATION</u> – 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
- Separation Agreement Form

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE. THE STATEMENT 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 RENDER INACCURATE OR UNTRUE, OR INCOMPLETE ANY STATEMENT MADE WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURED MAY WITHDRAW OR MODIFY AN 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 MAKING A DETERMINATION TO ISSUE A POLICY.

THE UNDERSIGNED INDIVIDUAL REPRESENTS THAT HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THIS REPRESENTATION, OR 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: ______________