



Squared Insurance Agency

Professional Liability and Life to the Power of 2

Facsimile Transmission

From: EPLI Department

Phone: 1-616-940-1101

Toll Free: 1-866-940-1101

Fax #: 1-616-940-1196

To: L Squared Insurance Date:

Agency LLC

Fax #: (616) 940-1196

RE: Employment Practices

Liability Insurance

Application

Number of Pages, including cover: 5



Please fax the attached application back to L Squared Insurance at (616) 940-1196 or email to Info@L2InsuranceAgency.com.

Carolina Casualty Insurance Company

4600 Touchton Road East, Building 100, Suite 400, Jacksonville, FL 32246

Proposal Form

Employment Practices Liability Insurance

CLAIMS MADE WARNING FOR APPLICATION

THIS PROPOSAL FORM IS FOR A CLAIMS MADE POLICY, RELATING TO CLAIMS MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the **Policy**. This Proposal Form is to be completed with respect to the entire Insured Entity. **Insured Entity** as used herein is defined to include the **Named Insured** and any **Subsidiaries**.

Name of **Named Insured**

Street Address

Suite

City

County

State

Zip Code

Website Address (if applicable)

Federal Employer Identification Number (FEIN)

The Officer designated as agent of the **Insured Entity** and of all **Insureds** to receive any and all notices from the **Insurer** or their authorized representatives concerning this insurance:

Contact Name

Title

E-mail Address

Telephone Number

Fax Number

Producer Information

Submitted by (Agency Name)

Dated

Agent's Name (Individual's Name)

Agent's License Number

Current Insurance Information (Provide details to all "Yes" answers by attachment)

1. Provide the following information regarding the **Insured Entity's** most recent insurance policies. If "None", so state.

Type of Policy	Insurance Carrier	Expiration Date	Limit of Liability	Deductible	Premium
Directors and Officers Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Employment Practices Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
General Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____

2. Has the Extended Reporting Period (or Discovery Period) been exercised for the **Insured Entity's** most recent Employment Practices Liability insurance policy? Yes No

3. Within the last 3 years, has any Directors and Officers Liability, Employment Practices Liability, or similar insurance for the **Insured Entity** ever been cancelled or non-renewed? Yes No

NOT APPLICABLE
IN MISSOURI
 Yes No

General Information (Provide details to all "Yes" answers by attachment)

4. The **Named Insured** has been in continuous operation since: _____

5. (a) What is the **Insured Entity's** Primary Standard Industrial Classification ("SIC") Code: _____

(b) Describe the **Insured Entity's** nature of operations: _____

6. (a) Form of organization: Cooperative Corporation Joint Venture
 Limited Liability Corporation Nonprofit Partnership

Sole Proprietorship Other: _____

(b) Type of organization: Manufacturing / Production Public Administration Retail Trade

Service Industry Web Based Wholesale Distributing

7. Is the **Named Insured** or any **Subsidiary** publicly held or a public reporting company under the Securities Exchange Act of 1934? Yes No

8. Provide the following financial information with respect to the **Insured Entity**:

Period Ending: ____ / ____ / ____

Assets (000): \$ _____ Annual Revenues (000): \$ _____
Equity (000): \$ _____ Operating Income / Loss (000): \$ _____

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9. (a) Is the **Insured Entity** currently in bankruptcy? Yes No
 (b) Within the next 12 months, is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code? Yes No
10. (a) Within the last 12 months, has the **Insured Entity** had any **Subsidiary**, plant, facility, branch or office closings, consolidations or layoffs? Yes No
 (b) Within the next 24 months, does the **Insured Entity** anticipate any **Subsidiary**, plant, facility, branch or office closings, consolidations or layoffs? Yes No
- If "Yes", provide the following details by attachment: Date of event; number of **Employees** affected; whether outside employment counsel was consulted; and, whether severance packages were offered to all **Employees** affected.
11. Within the last 3 years, has there been any change (resignations, departures, retirements, etc.) in the position of the Chairman of the Board, President, Chief Executive Officer or Chief Financial Officer? Yes No
 If "Yes", provide the following details by attachment: Name of individual; date of change; and reason for change.
12. Provide the following information on all Subsidiaries of the **Insured Entity**. If "None", so state. None

<u>Subsidiary Name</u>	<u>Nature of Business</u>	<u>Percent Owned by the Insured Entity</u>	<u>Date Created or Acquired</u>	<u>Domestic / Foreign</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES IN QUESTION 12. UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED BY ATTACHMENT.

Current Employee Information

13. (a) Number of **Employees**: Do not include Leased **Employees** or Independent Contractors in numbers below.
- | | <u>Full Time</u> | <u>Part Time</u> | <u>Seasonal</u> | <u>Temporary</u> | <u>Volunteers</u> |
|---------------|------------------|------------------|-----------------|------------------|-------------------|
| Current Year: | | | | | |
| Last Year: | | | | | |
- (b) How many Leased **Employees** does the **Insured Entity** employ annually? _____
 (c) How many Independent Contractors does the **Insured Entity** employ annually? _____
 (d) What is the **Insured Entity's** annual **Employee** turnover rate for the last 12 months? _____ %
14. What percentage of the **Insured Entity's Employees** work with the general public, work at customer locations or perform a majority of their functions off-site? _____ %
15. What percentage of the **Insured Entity's Employees** currently earns more than \$100,000? _____ %
16. Provide the following information on all plants, facilities, branches or offices of the **Insured Entity**. If "None", so state. None
- | <u>Location</u> | <u>Nature of Business</u> | <u>Estimated Number of Employees</u> | <u>Domestic / Foreign</u> |
|-----------------|---------------------------|--------------------------------------|---------------------------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
17. (a) Does the **Insured Entity** currently employ a full time Human Resources professional? Yes No
 If "Yes", what is the name and title of the senior Human Resources professional?
 Name: _____ Title: _____
 If "No", what is the name and title of the person who performs the Human Resource function?
 Name: _____ Title: _____
- (b) Does the **Insured Entity** currently utilize employment counsel? Yes No
 If "Yes", what is the name of the firm utilized? Firm: _____
18. Does the **Insured Entity** (details to "Yes" or "No" answers are not required by attachment):
- (a) Utilize employment applications for all prospective **Employees**? Yes No
 (b) Require the Human Resource Department to review and approve each proposed **Employee** termination? Yes No
 (c) Have outside employment counsel review each proposed **Employee** termination? Yes No
 (d) Maintain a written policy prohibiting Sexual Harassment and distribute that policy to all **Employees**? Yes No
 (e) Conduct mandatory periodic **Employee** education regarding prohibited forms of harassment? Yes No
 (f) Periodically have its employment policies and procedures reviewed by outside employment counsel? Yes No
 (g) Periodically have its employment policies and procedures distributed to all **Employees**? Yes No
 (h) Have a written procedure for notification and handling of employment related grievances, disputes, notifications, or claims? Yes No

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19. Indicate which formal written policies and procedures have been implemented and attach a copy of each. If "None", so None state.
- | | | |
|---|---|--|
| <input type="checkbox"/> Employee Handbook / Manual | <input type="checkbox"/> Anti-Harassment Policy, including Sexual Harassment | <u>Employers with more than 50 Employees</u> |
| <input type="checkbox"/> Anti-Discrimination Policy – Equal Employment Opportunity (EEO) Policy | <input type="checkbox"/> Adherence to Employment "at-will" relationship with all Employees | <input type="checkbox"/> Family Medical Leave Act
<u>California Employers Only</u>
<input type="checkbox"/> California Family Rights Act |

Litigation and Claim Information (Provide details to all "Yes" answers by attachment)

20. During the last 5 years, has any **Insured** known of, or been involved in any lawsuit, charges, inquiries, investigations, grievances or other administrative hearings or proceedings before any of the following agencies and/or in any of the following forums, including both domestic or foreign equivalents?
- | | |
|--|--|
| (a) National Labor Relations Board? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) Equal Employment Opportunity Commission? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) Office of Federal Contract Compliance Programs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (d) U.S. Department of Labor? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (e) Any state or local government agency such as the Labor Department or fair employment agency? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (f) U.S. District or state court? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
21. During the last 5 years, has any current or former **Employee** or third party made any **Claim**, or otherwise alleged discrimination, harassment, wrongful discharge and/or **Wrongful Acts** against any **Insured**? Yes No
 A **Claim** is not limited to the filing of a lawsuit or complaint with the Equal Employment Opportunity Commission or similar state or local agency. A **Claim** may also include a written demand by any current or former **Employee** seeking relief in connection with an employment-related dispute or grievance.
22. Is any **Insured** aware of any fact, circumstance or situation involving any **Insureds** that might reasonably be expected to result in a **Claim**, including, but not limited to, situations involving:
- | | |
|--|--|
| (a) Threats by any current or former Employee or third party to take legal or other action against any Insured , or a demand or request by any current or former Employee for monetary or non-monetary relief, arising out of any alleged discrimination, harassment, wrongful termination, constructive discharge, or other Wrongful Acts ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) Knowledge that any current or former Employee is engaging in, or has engaged in, acts of discrimination, harassment, or other Wrongful Acts ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) Complaints or accusations by other Employees or third parties that a current or former Employee is engaging in, or has engaged in, acts of discrimination, harassment, or other Wrongful Acts ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (d) Warnings, reprimands, or other disciplinary measures taken against any current or former Employee for acts of discrimination, harassment, or other Wrongful Acts ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

IF "YES" TO ANY PART OF QUESTIONS 20., 21., OR 22., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

- | | | | |
|----------------------------------|--|---------------------|--------------------|
| (a) Date Claim first made | (b) Claimant's Name | (c) Allegation | (d) Current Status |
| (e) Demand Amount | (f) Settlement (Indemnity) or Reserve Amount | (g) Attorney's fees | |

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTIONS 20., 21., OR 22.

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NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO NEW MEXICO, PENNSYLVANIA APPLICANTS: 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 SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO APPLICANTS OF 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.

NOTICE TO APPLICANTS OF FLORIDA, MINNESOTA, NEW JERSEY, OHIO, AND OKLAHOMA: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, MASSACHUSETTS, TENNESSEE, VIRGINIA, AND WASHINGTON APPLICANTS: 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.

Please Read Carefully

The undersigned, acting on behalf of all **Insureds**, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each and every **Insured** proposed for this insurance to facilitate the proper and accurate completion of this Proposal Form.

The undersigned agree that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and that they are material and are the basis of the insurance contract. The undersigned further agree that the Proposal Form and any material submitted herewith shall be considered attached to and a part of the **Policy**. Any material submitted with the Proposal Form shall be maintained on file (either electronically or paper) with the **Insurer** and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the **Policy** inception date, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any **Policy**, if issued, will be in reliance upon the truth of such representations; provided, however, with respect to such statements and representations, no knowledge or information possessed by any **Insureds** shall be imputed to any other **Insureds**. If any person or persons knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons. However, if the Chairperson of the Board of Directors, President, Chief Executive Officer, or Chief Financial Officer of the **Insured Entity** knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons and the **Insured Entity**;
- this Proposal Form has been completed as respects the entire **Insured Entity**;
- the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

Dated President, Chief Executive Officer, or equivalent position (Signature)

Title President, Chief Executive Officer, or equivalent position (Print Name)

Dated Human Resources Manager, or equivalent position (Signature)

This Carolina Casualty Insurance Company Proposal Form, including any material submitted herewith, shall be held in strictest confidence.

A POLICY CANNOT BE ISSUED UNLESS THE PROPOSAL FORM IS PROPERLY SIGNED AND DATED.

Please submit this Proposal Form including appropriate documentation to:

L Squared Insurance Agency LLC 5075 Cascade Road Suite E, Grand Rapids, MI 49546 (Fax) (616) 940-1196 (Email: Info@L2InsuranceAgency.com)