



**NEW BUSINESS APPLICATION FOR  
EMPLOYMENT PRACTICES  
LIABILITY INSURANCE**

**Farmington Casualty Company**  
Hartford, CT 06183

**This application is for a claims-made policy which includes defense expense within the limits of coverages.  
If issued, read your policy carefully.**

AGENCY BROKER	CODE	NAME and LICENSE NUMBER	POLICY NUMBER
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**CONTACT INFORMATION FOR RISK MANAGEMENT SERVICES**

The policy for which application is made includes free risk management services. Please provide the name and contact information for the individual responsible for overseeing Human Resource matters for access to the program.

Contact Name: \_\_\_\_\_ Contact Email: \_\_\_\_\_  
Title: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

**GENERAL INFORMATION**

- 1. Named Insured: \_\_\_\_\_
- 2a. Address: \_\_\_\_\_
- 2b. City: \_\_\_\_\_
- 2c. County: \_\_\_\_\_
- 2d. State: \_\_\_\_\_
- 2e. Zip: \_\_\_\_\_
- 3a. Person to contact: \_\_\_\_\_
- 3b. Telephone: \_\_\_\_\_
- 4a. Business is:  Corporation  Individual Proprietor  Partnership  Other (Specify) \_\_\_\_\_
- 4b. Business Ownership:  Public  Private  Non-Profit  Other (Specify) \_\_\_\_\_
- 5a. Nature of business: \_\_\_\_\_
- 5b. Number of years under current management: \_\_\_\_\_
- 6a. Number of employees by state (including #2. above): \_\_\_\_\_
- 6b. Number of locations by state or country (if foreign): \_\_\_\_\_
- 7. Desired Limit: Please check one  \$250,000  \$500,000  \$1,000,000  \$2,000,000  \$3,000,000  
 \$4,000,000  \$5,000,000
- 8. Desired Retention: Please check one  \$5,000  \$10,000  \$15,000  \$25,000  Other \$ \_\_\_\_\_
- 9. Desired Effective Date: \_\_\_\_\_
- 10. Describe prior coverage for the past three years (if any):

Policy Period/ Retroactive Date*	Insurer	Premium	Limits	Retention/Co- insurance %

\*Please specify retroactive date of expiring EPLI policy, if applicable.

- 11. Other insurance in force:
  - Directors' & Officers' Liability: Insurer: \_\_\_\_\_ Limit: \_\_\_\_\_
  - General Liability: Insurer: \_\_\_\_\_ Limit: \_\_\_\_\_

12. Please attach on a separate sheet a list of subsidiaries. Please note that all subsidiaries must be listed to be covered under the Policy.

## EMPLOYEES

1. Total number of employees, including directors and officers (all locations):

Non-Union:	Full-Time _____	Part-Time _____	Temporary _____
Union:	Full-Time _____	Part-Time _____	Temporary _____
Leased Employees:	Full-Time _____	Part-Time _____	
Independent Contractors:	Full-Time _____	Part-Time _____	

2. Total number of employees for the last three years (all locations):

Latest Year \_\_\_\_\_ Second Year \_\_\_\_\_ Third Year \_\_\_\_\_

**3. Annual employee turnover rate for the last three years (all locations):**

Latest Year \_\_\_\_\_ % Second Year \_\_\_\_\_ % Third Year \_\_\_\_\_ %

**4. How many employees have been involuntarily terminated in the past three years (all locations):**

Full-Time:	Latest Year _____	Second Year _____	Third Year _____
Part-Time:	Latest Year _____	Second Year _____	Third Year _____

5. Have you had any EEOC or NLRB charges, state and local judgments, and demand letters from current or former employees or their attorneys received by the applicant in the past five years? Include for each the applicable dates, damages incurred, legal expenses, current status, and a brief description of circumstances. Also indicate the valuation date and source of this data.

\_\_ Yes \_\_ No

**If yes, please provide details on a separate sheet.**

6. Have you had any lawsuits, mediations, arbitrations or negotiated settlements entered into with any current or former employee by the applicant for the past five years? Include for each, the applicable dates, jurisdiction, Civil Action or Index Number, legal expenses incurred, current status, and a brief description of circumstances. Also provide the valuation date and source of this data.

\_\_ Yes \_\_ No

**If yes, please provide details on a separate sheet.**

7. Are you aware of any circumstances which might give rise to a claim under this Policy?

\_\_ Yes \_\_ No

**If yes, please provide details on a separate sheet.**

**It is agreed that any claim(s) arising from any facts, circumstances or situations mentioned in Questions 5., 6. or 7. above are excluded from coverage.**

## HUMAN RESOURCES

1. Do you have a full-time human resource coordinator? Yes  No
2. Do you have a written policy addressing both sexual and non-sexual harassment? Yes  No
3. Do you have written annual evaluations for employees? Yes  No
4. Do you have a written grievance procedure in place? Yes  No
5. Do you use any tests for screening applicants or for continued employment? Yes  No
6. Do you have a written policy with respect to progressive discipline for employees? Yes  No
7. Do you have a written policy for Family Medical Leave? Yes  No
8. Do you have a written employee handbook? Yes  No
9. Do you use outside counsel for employment advice? Yes  No
10. Do you use a formal outplacement program for terminated/laid-off employees? Yes  No
11. Do you post, in a conspicuous place, all required notices pertaining to equal employment opportunity laws? Yes  No
12. Do you have an alternative dispute resolution system? Yes  No
13. Do all employees receive training in the proper implementation of your human resources policies and procedures? (If yes, please attach a separate sheet providing a brief description of the training and the average number of hours each employee is required to take.) Yes  No



**ATTENTION: INSUREDS IN NY**

**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.**

Applicant's Authorized Signature: \_\_\_\_\_  
(Owner, President, CEO, Managing or General Partner, or Head of HR)

Applicant's Title: \_\_\_\_\_

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

**Signature must be dated within 30 days prior to bind date.**

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

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_

Facsimile: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Attention: Insureds in AR, FL, KY, ME, MN, NJ, OH, and PA**

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.

***Attention: Insureds in DC:***

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

***Attention: Insureds in NY***

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.

***Attention: Insureds in CO***

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

***Attention: Insureds in TN and VA***

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.

***Attention: Insureds in LA and NM***

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.

***Attention: Insureds in OK***

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

*Attaches to all Applications*



## **IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE**

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: [www.travelers.com/w3c/legal/Producer\\_Compensation\\_Disclosure.html](http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html)

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.