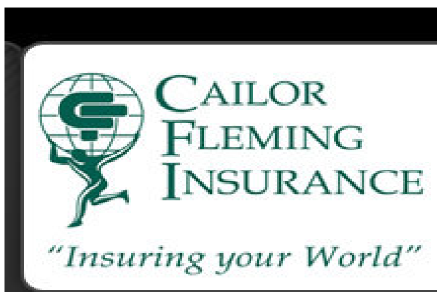


4610 Market Street
Youngstown, OH 44513

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# Medical Providers Employment Practices Protection Application

All questions must be answered and application must be signed by the applicant. This is an application for a claims made policy. Please read your policy carefully.

## BACKGROUND INFORMATION

***(Note – press the TAB key or use your mouse to move from field to field, press F1 for help on any question)***

Name of Applicant (Corporate Name):
Address:
City: State: Zip Code:
Phone number: Website Address:
E-mail address:
Description of Operations (include each specialty)

Full time employees Part time Temporary/Seasonal Independent Contractors Leased

How many of the above employees/independent contractors are located in: California Louisiana Outside the U.S.

## SECTION I: UNDERWRITING INFORMATION

1. Have any entities proposed for insurance been in business less than three years? ☐Yes ☐No
2. Do more than 50% of all employees (not Principals or Partners) currently earn more than $100,000? ☐Yes ☐No
3. a) Is the Applicant a Subsidiary of another organization? ☐Yes ☐No
   b) Is the Applicant a franchisee of another organization? ☐Yes ☐No
   c) Name of Parent and/or Franchisor and Location
4. Does the Applicant want any Subsidiary(s) covered? If "Yes," include employees in employee count above and provide: ☐Yes ☐No
   a) Name of Subsidiary(s)
   b) Is the Subsidiary(s) at least 50% owned by the Applicant? ☐Yes ☐No
   c) Does the Subsidiary(s) fall within the same class of business as the Applicant? ☐Yes ☐No
5. Expiring Insurance Information:
   Carrier Limits Retention Premium
   Written Guideline Requirements:
   a) Does each entity proposed for Insurance have a written Email/Internet Policy currently in place or is willing to implement one? ☐Yes ☐No
   b) Does each entity proposed for insurance have a written Anti-Discrimination and Anti-Harassment Policy currently in place? ☐Yes ☐No
   c) Has the Applicant ever denied or had a policy against providing medical or dental services to any person based on sexual orientation or communicable disease including HIV/AIDS? ☐Yes ☐No

   **(Attach a statement of details for all "yes" answers to the following questions)**
6. Has any entity proposed for insurance closed, downsized, laid off, reduced staff, sold, merged with or acquired any company in the past 12 months or anticipate doing so in the next 12 months? ☐Yes ☐No
7. Within the last 5 years has any third party discrimination, third party harassment, patient molestation or employment related: inquiry, complaint, notice of hearing, claim or suit been made against any entity proposed for insurance or any person proposed for Insurance in the capacity of either Director, Officer, Member (if an LLC) or Employee of any entity proposed for insurance?
   If "Yes" complete USLI Claim Supplement for each claim ☐Yes ☐No
8. Is any person proposed for this Insurance aware of any fact, circumstance or situation which may result in an employment claim or third party discrimination or third party harassment or patient molestation claim against any entity proposed for insurance or any of its Directors, Officers, Members (if an LLC) or Employees?
   If "Yes," complete USLI Claim Supplement for each claim ☐Yes ☐No
9. Has any Policy for Employment Practices Liability Insurance ever been cancelled or non-renewed? ☐Yes ☐No

Applicant's Signature: ____________________________________________ Title: Date:
President, Chairperson of the Board, Managing Member, Executive Director or Partner

## SECTION II: ADDITIONAL APPLICANT INFORMATION

Applicant's Mailing Address: City: State: Zip:

**Arizona Notice:** Misrepresentations, omissions, concealment of facts and incorrect statements shall prevent recovery under the policy only if the misrepresentations, omissions, concealment of facts or incorrect statements are; fraudulent or material either to the acceptance of the risk, or to the hazard assumed by the insurer or the insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

**Florida and Illinois Notice:** I understand that there is no coverage for punitive damages assessed directly against an insured under Florida and Illinois law. However, I also understand that punitive damages that are not assessed directly against an insured, also known as "vicariously assessed punitive damages", are insurable under Florida and Illinois law. Therefore, if any Policy is issued to the Applicant as a result of this Application and such Policy provides coverage for punitive damages, I understand and acknowledge that the coverage for Claims brought in the State of Florida and Illinois is limited to "vicariously assessed punitive damages" and that there is no coverage for directly assessed punitive damages

**Minnesota Notice:** Authorization or agreement to bind the insurance may be withdrawn or modified only based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for nonpayment of premium.

**New York Disclosure Notice:** This policy is written on a claims made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged Wrongful Acts or Patient Molestation that took place prior to retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect for incidents reported during the Policy Period or any subsequent renewal of this Policy or any extended reporting period and all coverage under the policy ceases upon termination of the policy

except for the automatic extended reporting period coverage unless the insured purchases additional extend reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The Insured may purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.

**Utah Notice:** I understand that Punitive Damages are not insurable in the state of Utah. There will be no coverage afforded for Punitive Damages for any Claim brought in the State of Utah. Any coverage for Punitive Damages will only apply if a Claim is filed in a state which allows punitive or exemplary damages to be insurable. This may apply if a Claim is brought in another state by a subsidiary or additional location(s) of the Named Insured, outside the state of Utah, for which coverage is sought under the same policy

**Virginia Notice:** This Policy is written on a claims-made basis. Please read the policy carefully to understand your coverage. You have an option to purchase a separate limit of liability for the extended reporting period,. If you do not elect this option, the limit of liability for the extended reporting period shall be part of the and not in addition to limit specified in the declarations. If you have any questions regarding the cost of an extended reporting period, please contact your insurance company or your insurance agent. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

**Colorado Fraud Statement:** 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.

**District of Columbia Fraud Statement:** WARNING: 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.

**Florida Fraud Statement:** 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.

**Kentucky Fraud Statement:** 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.

**Maine and Washington Fraud Statement:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**New Jersey Fraud Statement:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New York Fraud Statement:** 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.

**Ohio Fraud Statement:** Any person who, with intent to defraud or knowing that he 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.
**Oklahoma Fraud Statement:** WARNING: 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.
**Pennsylvania Fraud Statement:** 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.
**Vermont Fraud Statement:** 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 may be subject to fines and confinement in prison.
**Tennessee and Virginia Fraud Statement:** 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.

If your state requires that we have information regarding your Authorized Retail Agent or Broker, please provide below.
Retail Agency Name: License #: Main Agency Phone Number: Agency Mailing Address: City:
State: Zip:

The signer of this application acknowledges and understands that the information provided in this Application is material to the Insurer's decision to provide the requested insurance and is relied on by the Insurer in providing such insurance. The signer of this application represents that the information provided in this Application is true and correct in all matters. The signer of this Application further represents that any changes in matters inquired about in this Application occurring prior to the effective date of coverage, which render the information provided herein untrue, incorrect or inaccurate in any way will be reported to the Insurer immediately in writing. The Insurer reserves the right to
modify or withdraw any quote or binder issued if such changes are material to the insurability or premium charged, based on the Insurer's underwriting guides. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the Policy.

- **Other instructions:**
    - **Please save a copy of this file for your records**
    - **You will need to sign and date this application as part of the policy binding process**

    **Any additional information:**