

Admiral Insurance Company

ExecSuite®

Proposal Form for Employment Practices Liability

CLAIMS MADE WARNING FOR APPLICATION: This Proposal Form is for a Claims Made and Reported Policy, relating to claims made against the Insureds during the Policy Period or any Extended Reporting Period that may apply.

- Complete the sections of this Proposal Form for each Coverage Requested as indicated below.
- Provide details to all "Yes" answers, when applicable, by attachment whether or not prior coverage was in place.

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**

Primary Location Street Address

Suite

City

County

State

Zip Code

Website Address (if applicable)

Federal Employer Identification Number (FEIN)

Name and title of the officer of the **Named Insured** designated to receive any and all notices from the **Insurer**.

E-mail Address

Telephone Number

Fax Number

The contact information provided will be used for internal purposes and will not be sold to any third party.

The mailing address is the same as the primary location. If not, provide mailing address:

Mailing Street Address

Suite

City

State

Zip Code

Coverage and Limit Requested

Indicate Coverage and Limit Requested:

- | | | |
|---|--|---------------------|
| Directors, Officers and Corporate Liability Insurance Coverage: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Limit Requested: \$ |
| Employment Practices Liability Insurance Coverage: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Limit Requested: \$ |
| Fiduciary Liability Insurance Coverage: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Limit Requested: \$ |

Indicate the Type of Limit Requested:

- Shared Limit of Liability for multiple **Coverage Sections**:
- Separate Limit of Liability for each **Coverage Section**:
- Combination of Shared and Separate Limits (provide details):

Current Insurance Information

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

Type of Coverage		Carrier	Expiration Date	Limit	Deductible	Premium
Directors and Officers Liability:	<input type="checkbox"/> None			\$	\$	\$
Employment Practices Liability:	<input type="checkbox"/> None			\$	\$	\$
Fiduciary Liability:	<input type="checkbox"/> None			\$	\$	\$
Cyber Liability/Data Breach:	<input type="checkbox"/> None			\$	\$	\$

2. Within the last 3 years, has any **Claim** been made or has notice been given under any of the above listed policies or similar insurance? Yes No
3. Within the last 3 years, have any of the above listed policies or similar insurance for the **Insured Entity** been cancelled or non-renewed? Yes No
(NOT APPLICABLE IN MISSOURI)

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General Information

4. (a) Form of organization:
- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Corporation | <input type="checkbox"/> Joint Venture* |
| <input type="checkbox"/> Limited Liability Corporation | <input type="checkbox"/> Nonprofit | <input type="checkbox"/> Partnership* |
| <input type="checkbox"/> Sole Proprietorship / Individual | <input type="checkbox"/> Other: _____ | |

*If a Joint Venture or Partnership, provide participation or ownership structure details by attachment.

- (b) Type of organization:
- | | | |
|---|--|---|
| <input type="checkbox"/> Manufacturing / Production | <input type="checkbox"/> Public Administration | <input type="checkbox"/> Retail Trade |
| <input type="checkbox"/> Service Industry | <input type="checkbox"/> Web Based | <input type="checkbox"/> Wholesale Distributing |
5. The **Named Insured** has been in continuous operation since: _____
6. (a) What is the **Insured Entity's** primary Standard Industrial Classification ("SIC") Code? _____
- (b) Describe the **Insured Entity's** nature of operations: _____

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**:

Assets (000):	\$	Annual Revenues (000):	\$	Cash:	\$
Equity (000):	\$	Net Income / Loss (000):	\$	Period Ending:	/ /

IF "YES" TO ANY PART OF QUESTION 9. OF THIS SECTION, PROVIDE DETAILS BY ATTACHMENT.

9. Answer each of the following questions with respect to the **Insured Entity's** recent 18-month history and expectations for the next 12 months:
- | | Last 18 months | Next 12 months |
|--|--|--|
| (a) filing a petition for protection under the bankruptcy code? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) any change (resignations, departures, retirements, etc.) in the position of the Chairman of the Board, President, Chief Executive Officer, Chief Financial Officer or Managing Partner (or equivalent position)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) raised or raising funds by any venture capital, private placement or private offering of any equity or debt securities? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (d) any public sale of equity or debt securities and/or the filing of any registration statement or similar disclosure for an offering or sale of securities? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (e) any plant, facility, branch or office closings, or layoffs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (f) any consolidation, divestment, acquisition, tender offer or merger? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (g) suspension by the secretary of state or state agency for failure to pay taxes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (h) violation of any debt or loan covenants? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
10. Provide the following information on all **Subsidiaries** of the **Insured Entity**. If "None", so state. None

Subsidiary Name	Nature of Business	Percent* Owned by Insured Entity	Date Created or Acquired	Domestic / Foreign	Nonprofit
		%			<input type="checkbox"/> Yes <input type="checkbox"/> No
		%			<input type="checkbox"/> Yes <input type="checkbox"/> No
		%			<input type="checkbox"/> Yes <input type="checkbox"/> No

*If **Subsidiary** is less than 100 percent owned, provide details of all other owners, by attachment.

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED HERE OR BY ATTACHMENT.

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Loss History Information

11. During the last 5 years, has any **Insured**, including any **Subsidiary**, received any written demands for monetary or non-monetary relief, been involved in, or had any knowledge of any civil or criminal action, administrative proceeding or arbitration, regulatory proceeding or investigation, including both domestic or foreign equivalents, involving:
- (a) any current or former employee or third party alleging discrimination, harassment, wrongful discharge and/or any wrongful employment act? Yes No
 - (b) the Equal Employment Opportunity Commission or any similar state or local agency? Yes No
 - (c) the National Labor Relations Board? Yes No
 - (d) actual or alleged violations of any wage and hour law, including but not limited to, the Fair Labor Standards Act? Yes No
 - (e) the U.S. Immigration and Customs Enforcement Agency? Yes No
 - (f) the Department of Justice, U.S. Department of Labor, Pension Benefit Guarantee Corporation, Securities and Exchange Commission, Internal Revenue Service or any similar state or local agency? Yes No
 - (g) any intellectual property disputes, including Copyright, Patent, or Trademark Laws? Yes No
 - (h) any security law or regulation, anti-trust or fair trade law, the Foreign Corrupt Practices Act or Office of Federal Contract Compliance Programs? Yes No
12. During the last 5 years has any **Insured**, including any **Subsidiary**, been involved in any lawsuit not disclosed above? Yes No

IF "YES" TO ANY PART OF QUESTIONS 11. OR 12. OF THIS SECTION, PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION BY ATTACHMENT:

- | | | | |
|--------------------------------|--|---------------------|---------------------------|
| (a) Date Allegation First Made | (b) Claimant's Name | (c) Allegation | (d) Current Status |
| (e) Demand Amount | (f) Settlement (Indemnity) or Reserve Amount | (g) Attorney's Fees | (h) Remedial Action Taken |

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 11. OR 12. OF THIS SECTION.

Employment Practices Liability Section

➤ Complete the Employment Practices Liability section of the Proposal Form only if requesting this coverage.

13. Complete the table:

	Current Year	Previous Year
(a) Total number of full-time employees in the U.S.:		
(b) Total number of part-time employees in the U.S.:		
(c) Total number of independent contractors in the U.S.:		
(d) Total number of leased, seasonal, temporary, volunteers and interns in the U.S.:		
(e) Regarding the above totals, number of employees located in California:		
(f) Total number of employees located outside the U.S.:		

14. What percentage of the **Insured Entity's Employees** currently earn more than \$100,000? _____ %

15. Provide the following information on all plants, facilities, branches or offices. If "None", so state. None

Location	Nature of Business	Number of Employees outside California	Number of Employees in California

16. What percentage of the **Insured Entity's** employees are "exempt" at each location? _____ %

17. Does the **Insured Entity** consult with an attorney regarding how overtime is calculated and how they define "exempt" employees for each location? Yes No

18. Does the **Insured Entity** currently employ a full-time Human Resources professional? Yes No

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19. Indicate which formal written policies and procedures have been implemented. If "None", so state. None
- | | |
|---|---|
| <input type="checkbox"/> Employee Handbook / Manual
<input type="checkbox"/> Adherence to Employment "at-will" relationship with all Employees
<input type="checkbox"/> Anti-Discrimination Equal Employment Opportunity Policy
<input type="checkbox"/> Anti-Harassment Policy, including Sexual Harassment
<input type="checkbox"/> Data Breach Notification/Data Security Policy
<input type="checkbox"/> Adherence to Genetic Information Nondiscrimination Act | <input type="checkbox"/> Social Media Policy
<input type="checkbox"/> I-9 Verification
<u>Employers with more than 50 Employees</u>
<input type="checkbox"/> Family Medical Leave Act
<u>California Employers Only</u>
<input type="checkbox"/> California Family Rights Act |
|---|---|
20. Does the **Insured Entity** (details to "Yes" or "No" answers are not required by attachment):
- (a) have outside employment counsel review each proposed **Employee** termination? Yes No
- (b) periodically have its employment policies and procedures reviewed by outside employment counsel and distributed to all **Employees**? Yes No
- (c) have a written procedure for notification and handling of employment related grievances, disputes, notifications, or claims? Yes No
21. Is any **Insured** aware of any fact, circumstance or situation involving any **Insureds** that might reasonably be expected to result in a **Claim** as defined in the Employment Practices Liability Insurance Coverage Section, 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**? Yes No
- (b) knowledge that any current or former employee is engaging in, or has engaged in, acts of discrimination, harassment, or other **Wrongful Acts**? Yes 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**? Yes No
- (d) warnings, reprimands, or other disciplinary measures taken against any current or former employee for acts of discrimination, harassment, or other **Wrongful Acts**? Yes No

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

(a) Date Allegation First Made	(b) Claimant's Name	(c) Allegation	(d) Current Status
(e) Demand Amount	(f) Settlement (Indemnity) or Reserve Amount	(g) Attorney's Fees	(h) Remedial Action Taken

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 QUESTION 21.

Producer Information

Submitted by (Agency Name) _____

Dated _____

Agent's Name (Individual's Name) _____

Agent's License Number _____

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Please Read Carefully

The undersigned, acting on behalf of all proposed **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 **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 information submitted herewith are their material representations 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 **Insured Person** shall be imputed to any other **Insured Person**. 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, and such statements materially affect either the acceptance of the risk or the hazard assumed by the **Insurer** under this **Policy**, then this **Policy** shall not apply as to that person or persons. However, if the President, Chief Executive Officer, Chief Financial Officer or Managing Partner 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, and such statements materially affect either the acceptance of the risk or the hazard assumed by the **Insurer** under this **Policy**, then this **Policy** shall not apply as to that person or persons and the **Insured Entity**;
- the information contained in this Proposal Form shall not be used by the **Insureds** as notice as provided for in section VII. of the Common Policy Terms and Conditions Section of this **Policy**;
- 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, Chief Financial Officer, or Managing Partner (Signature)

President, Chief Executive Officer, Chief Financial Officer, or Managing Partner (Print Name)

Title

Dated

Human Resources Manager, or equivalent position (Signature)

This Admiral 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:
Monitor Liability Managers, 233 S. Wacker Drive, Suite 3900
Chicago, IL 60606

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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 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 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 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.

NOTICE TO OHIO APPLICANTS: 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.

NOTICE TO APPLICANTS OF 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.

NOTICE TO ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, AND RHODE ISLAND APPLICANTS: 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.

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 MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO OREGON APPLICANTS: 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 MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.