



Allied World Insurance Company ("Insurer")

All questions must be answered and the application must be dated and signed before a quotation is given.

Return to: American Professional Agency, Inc. 95 Broadway, Amityville, NY 11701 (631) 691-6400 • (800) 421-6694

EMPLOYMENT PRACTICES LIABILITY DEFENSE ONLY SUPPLEMENTAL APPLICATION FOR SOCIAL SERVICE AGENCY PROFESSIONAL LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

This application will only be considered valid if submitted with a completed and signed general Application.

APPLICANT INFORMATION

Applicant Name: _____

REQUESTED COVERAGE

Employment Practices Claims-Made Coverage

Effective Date: _____ Retroactive Date: _____

Limit: \$25,000

Deductible: [] \$0K [] \$5K [] \$10K [] \$25K [] Other \$ _____

EMPLOYMENT PRACTICES LIABILITY EXPOSURE

1. Is the Applicant requesting Employment Practices Defense Only Liability Coverage (EPLI)? [] Yes [] No

If "Yes," number of employees? FT: _____ PT: _____

2. Does the Applicant or any other entity proposed for coverage have EPLI coverage under any policy (i.e. D&O)? If so, EPLI is not available on this policy. [] Yes [] No

If "Yes," please describe: _____

3. Does the Applicant and every other entity proposed for coverage have an employee handbook? [] Yes [] No

4. Has the Applicant or any proposed insured had any EPL claims brought against them in the past five years? (Including those closed with no payment.) If yes, please give full particulars in order for your application to be considered. [] Yes [] No

5. Has the Applicant or any proposed insured had any EEOC proceedings brought against them? [] Yes [] No

If "Yes," please describe in an attachment hereto.

HIRING, SCREENING AND TRAINING PROCEDURES FOR EMPLOYEES AND CONTRACTORS, AND PROVIDER CREDENTIALS

6. Do screening/hiring procedures include the following?

A) Educational background [] Yes [] No

- B) Previous employers/employment history Yes No
- C) Personal references Yes No
- D) Criminal background check: Yes No
 County Yes No
 State Yes No
 Federal Yes No
- E) Professional liability claims history Yes No
- F) Drug/alcohol abuse screening Yes No
7. Are each of the above procedures followed and documented? Yes No
 If "No," please explain: _____
8. How often does the Applicant perform recredentialing and update its list of specific privileges? _____

9. Has any facility proposed for coverage been required to notify the National Practitioner Data Bank of any license suspension, peer review action or professional liability payment involving any member of the medical staff? Yes No
10. Are written job descriptions established for all employees? Yes No
11. Is a competency-based checklist used to assess and document staff skills? Yes No
 If "No," please explain: _____

INSURANCE INFORMATION

Please provide the following information for Employment Practices Liability Insurance for the current policy year and previous four years.

Policy Period	Carrier	Limits	Deductible or SIR	Claims Made or Occurrence	Retro Date	Premium

FRAUD WARNING

NOTICE TO FLORIDA APPLICANTS: "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."

APPLICANT SIGNATURE

I hereby acknowledge that the above information is complete and accurate to the best of my knowledge and belief.

Print Name of Authorized Representative: _____

Signature of Authorized Representative: _____

Title: _____

Date: _____

This Application must be completed, dated and signed by the CEO, CFO, Administrator, Executive Director or Risk Manager of the Applicant, who is authorized to sign on behalf of all proposed Insureds.