ALLIED WORLD
A FAIRFAX Company

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

LOUISIANA 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

NOTICES TO APPLICANT & FRAUD WARNING

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Insurer in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. The Application is on file with the Insurer, and shall be deemed to be attached to, and made a part of, and incorporated into the Policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the Policy, the Applicant will immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO LOUISIANA 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."

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.

Email Form **Print Form**

Save form first on your computer before emailing.