UNDERWRITERS DIRECT ACCESS

Salt Lake City Area Office
8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
800-257-5590 • Fax 800-478-9880

Chicago Office
303 W. Madison Street Suite 2075
Chicago, IL 60606
800-456-4576 • Fax 312-408-8081

EMPLOYMENT CONDITIONS

General Information Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: ( )_____ Fax: ( )_____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Producer No.: _____ Producer's Name: _____

Producer's E-mail: _____

Detailed description of business activities (specifically, and by location): _____

_____

_____

_____

Is this a new business? **o** Yes **o** No If no, how many years have you been in business? _____

Applicant is: **o** Individual **o** Corporation **o** Partnership **o** Joint Venture

o Other (please describe): _____

Annual Payroll: $ _____

Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? **o** Yes **o** No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: ( )_____

Fax: ( )_____ Years with Company: _____

Employee's Responsibilities: _____

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor or related person or entity ever had a claim? **o** Yes **o** No

Has the Applicant or any predecessor ever had a claim? **o** Yes **o** No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? **o** Yes **o** No

If yes, please explain: _____

_____

_____

_____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? **o** Yes **o** No

If the standard markets are declining placement, please explain why: _____

_____

_____

_____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? **o** Yes **o** No

If the standard markets are declining placement, please explain why: _____

_____

2. Desired Insurance

Limit of Liability:

	Per Act/Aggregate	OR	Per Person/Per Act/Aggregate
o	$50,000/$100,000	**o**	$25,000/$50,000/$100,000
o	$150,000/$300,000	**o**	$75,000/$150,000/$300,000
o	$250,000/$1,000,000	**o**	$100,000/$250,000/$1,000,000
o	$500,000/$1,000,000	**o**	$250,000/$500,000/$1,000,000
o	Other: _____	**o**	Other: _____

Self-Insured Retention (SIR): **o** $1,000 (Minimum) **o** $1,500 **o** $2,500 **o** $5,000 **o** $10,000

3. Business Activities

1. Person providing accounting and tax services:
   a. Name: _____
   b. Address: _____

2. Show all other insured locations, including addresses and corporate names (e.g., subsidiaries):

LOCATION #	NAME OF INSURED ENTITY & RELATIONSHIP TO APPLICANT	COMPLETE ADDRESS	YEARS IN BUSINESS
1			
2			
3			
4			
5			

3. Indicate whether any proposed Applicant is (check each applicable item):

   o Foreign-owned corporation **o** Publicly held

   o Contractor with Federal Government **o** Contractor with any State Government

4. Describe business activities and SIC codes applicable to each insured location and show number of all employees.

LOCATION #	PRIMARY BUSINESS ACTIVITY AT LOCATION	SIC CODE(S)	# OF FULL TIME EMPLOYEES	# OF PART TIME EMPLOYEES	# OF SEASONAL EMPLOYEES
1					
2					
3					
4					
5					

5. Indicate employment turnover at each insured location during the last three years (in columns asking for terminations show separate figures for voluntary and involuntary terminations):

	HIRED			TERMINATED					
LOCATION NO.	# FULL TIME	# PART TIME	# SEASONAL	FULL TIME		PART TIME		SEASONAL	
				Vol.	Invol.	Vol.	Invol.	Vol.	Invol.
1									
2									
3									
4									
5									

6. Indicate estimated employment turnover for each insured location for the next twelve months: (<u>in columns asking for terminations, show separate figures for voluntary and involuntary terminations</u>):

	HIRED			TERMINATED		
LOCATION	# FULL TIME	# PART TIME	# SEASONAL	FULL TIME	PART TIME	SEASONAL

NO.				Vol.	Invol.	Vol.	Invol.	Vol.	Invol.
1									
2									
3									
4									
5									

7. Indicate number of employees for each insured location by length of employment.

LOCATION NO.	LESS THAN 2 YRS.	2-5 YEARS	6-10 YEARS	11-20 YEARS	OVER 20 YEARS
1					
2					
3					
4					
5					

8. Indicate number of persons serving as partners, directors, and officers by annual salary range (use salary range, note and show number on each line).

SALARY	PARTNERS	DIRECTOR/OFFICER	OUTSIDE DIRECTOR	OFFICERS
50,000 or less				
50,000 to 100,000				
100,000 to 200,000				
200,000 to 300,000				
Over 300,000				

9. Name(s) of person(s) responsible for personnel, human resources, labor relations, and industrial Safety (indicate precisely all the duties and authority of each such person):

NAMES	DUTIES	AUTHORITY

10. If there have been any charges filed with the EEOC or state agency against any insured location, whether by current employees, terminated employees, or employees not hired, over the last seven years, please note location and year:

LOCATION NO.	YR:_____	YR:_____	YR:_____	YR:_____	YR:_____	YR:_____	YR:_____
1							
2							
3							
4							
5							

Of the total number of EEOC/state agency charges filed, indicate the primary allegations as follows:

LOCATION NO.	DISCRIMINATION						
	RACIAL	AGE	RELIGIOUS	ETHNIC	EQUAL PAY	SEX	ADA
1							
2							
3							
4							
5							

11. With respect to litigated cases and EEOC/state agency charges over the last seven years, for which any settlement was or may be paid, please provide the following information, which must be currently valued:

DATE OF OCCURRENCE	CLAIMANT	ALLEGATION	DAMAGES PAID	DAMAGES RESERVED	LEGAL EXPENSE	LEGAL EXPENSE PAID

12. Describe all procedures for disciplining and terminating employees, including grievance or review procedures, and procedures for investigating employee complaints about working conditions, sexual harassment, and pay disparities:

_____

_____

_____

FUTURE PLANS

13. Does any proposed Applicant or location plan to close any office or plant during the next twelve months? ☐ Yes ☐ No

    If yes, please explain: _____

    _____

14. Does management of any insured, at any location, plan to form any new businesses, open any new locations or acquire any new companies during the next twelve months? ☐ Yes ☐ No

    If yes please explain: _____

    _____

    _____

15. Is management of any insured, at any location, aware of any facts, incidents, or circumstances that may result in claims being made against any insured in the next twelve months? ☐ Yes ☐ No

    If yes, please explain: _____

    _____

    _____

ADDED REQUIREMENT

16. The following additional documents and information must accompany this Application, which will form a part of the Application, for underwriting and rating qualification purposes (check those that are submitted with this Application):

- ☐ Copy any of EEOC claim filings in the last seven years.
- ☐ Your current financial statements
- ☐ Your employee benefits handbook
- ☐ Your employee evaluation forms used
- ☐ Any copies of affirmative action plans to prevent future claims (if applicable)
- ☐ Your employment application forms used
- ☐ Your last audited financial statements (if any)
- ☐ Your supervisory and employment manuals/rules
- ☐ Your collective bargaining agreements (if applicable)

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer’s accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant’s facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name