THE CIA APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY

Cossio Insurance Agency • 864-688-0121 • Fax: 864-688-0138 • PO Box 188 Simpsonville SC 29681

DIRECTIONS:

1. Complete the enrollment form (all pages) in full by filling in the blue fields.
2. Please fill in all the fields with the correct information.
3. Mail the completed quote request form to:
   PO Box 188 Simpsonville SC 29681 or email the application to apps@cossioinsurance.com

Section 1: GENERAL INFORMATION

How did you hear about us? ...

Parent Company

Address:

City:	State:	Zip:

State of Incorporation:	Date Established:	Yrs. Under Current Mgmt.:
DOB:	FEIN/SS:	Nature of Business:

Limits Requested$ Policy Period requested: From to

Officer of the Parent Company designated to receive any and all notices from the Insurer or the Insurer's authorized representative(s) concerning this coverage:

Parent Company is a: ☐ Corporation ☐ Individual ☐ Partnership ☐ Other:

Coverage Desired: ☐ Duty to Defend ☐ Non-Duty to Defend

Section 2: EMPLOYEES

Total number of Emplyees: Worldwide US California Texas
Michigan Union Non-Union

Employees (including all locations and all directors and officers):

Employees on Payroll	Total (Current #)	Total (12 mo. prior)	Total (24 mo. prior)	Anticipated (next 12 mo.)
Full-time				
Part-time				
Temporary Workers				

Please include Employees of all Subsidiaries more than 50% owned, for which coverage is desired

# of Full-time Employees by length of service: < than 5 years: ; > than 5 years:

#of Employees terminated or involuntarily laid off in: the past 12 mos.? ; the past 24 mos.?

# of Employees with total annual compensation greater than $100,000?

Annual Employee turnover rate for each of the last 3 years:

Year Percent Turnover %
Year Percent Turnover %
Year Percent Turnover %

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Section 3: ADDITIONAL INSUREDS

Is coverage desired for Leased Workers and/or Independent Contractors? ☐ Yes ☐ No

If Yes, please complete the following table and supply a schedule naming said individuals.

Additional Insured	Total (Current #)	Total (12 mo. prior)	Total (24 mo. prior)	Anticipated (next 12 mo.)
Leased Workers				
Independent Contractors				

If coverage is desired for Leased Workers and/or Independent Contractors, are said individuals subject to the same employment related human resource training/procedures as traditional Employees? ☐ Yes ☐ No

If No, please explain.

Section 4: HUMAN RESOURCES

Does the Parent Company:

Use outside employment counsel for employment advice? ☐ Yes ☐ No

If No, please explain how this function is handled.

Have a full time human resources manager or department? ☐ Yes ☐ No

If No, please explain how this function is handled.

Distribute an employee handbook to all Employees? ☐ Yes ☐ No

If No, please explain.

Have a manual of its human resource procedures? ☐ Yes ☐ No

If Yes, indicate the date it was last revised:

Provide formal training for its supervisors in administering these procedures? ☐ Yes ☐ No

Have a written policy against Discrimination, including sexual harassment? ☐ Yes ☐ No

If Yes, how is it communicated to Employees?

Have a grievance procedure for dealing with Discrimination claims? ☐ Yes ☐ No

Use any tests (e.g. psychological, drug, polygraph, etc.) for screening applicants or for continued employment or promotion? ☐ Yes ☐ No If Yes, attach details.

Use an employment application for all applicants? ☐ Yes ☐ No

If No, please explain:

Have a written progressive disciplinary program? ☐ Yes ☐ No

Obtain advice from counsel or human resource manager prior to terminating an Employee? ☐ Yes ☐ No If No, attach details.

Section 5: OPERATIONAL CHANGES

Has the Parent Company, or any of its Subsidiaries conducted any branch/facility closings, branch/facilities sales, layoffs and/or staff reductions during the past 24 months?: ☐ Yes ☐ No If Yes, attach details.

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Section 5: OPERATIONAL CHANGES (Continued)

Has the Parent Company, or any of its Subsidiaries been involved in any actual or proposed merger, acquisition, tender offer, divestment orpurchase and assumption within the past 24 months?:
☐ Yes ☐ No If Yes, attach details.

Does the Parent Company, or any of its Subsidiaries, anticipate:

Any branch/facility closings, branch/facility sales, layoffs and/or staff reductions within the next 12 months? ☐ Yes ☐ No If Yes, attach details.

Any mergers and/or acquisitions, of any type, during the next 12 months? ☐ Yes ☐ No
If Yes, attach details.

Or intend to out-source any of its current activities? ☐ Yes ☐ No If Yes, attach details.

Section 6: PAST ACTIVITIES

Has the Parent Company, any Subsidiary, any director, officer or other proposed Insured had any:

EEOC or NLRB charges, state and/or local judgments, demand letters from current or former Employees or their attorneys? ☐ Yes ☐ No If Yes, please provide the following information: applicable dates, party(ies) named, damage!! ineurred, legal expenses, current status, a brief description of the circumstances. Also please indicate the valuation date and source of this data.

Lawsuits, mediations, arbitrations or negotiated settlements with any current or former Employee?
☐ Yes ☐ No If Yes, please provide for each, the applicable dates, party(ies) named, jurisdiction, Civil Action or Index Number, legal expenses incurred, current status, and brief description of circumstances.

It is agreed that any Claim(s) arising from any facts, circumstances or situations mentioned in the two questions immediately above, are excluded from coverage.

Section 7: INSURANCE

Do you currently have employment practices liability insurance? ☐ Yes ☐ No

If Yes, please provide:
Insurer: Limits: Deductible: Premium: Exp. Date:

Has the Parent Company, any Subsidiary or any proposed Insured Person given written notice under the provisions of any prior or current employment practices liability policy or any similar insurance or endorsement of specific facts or circumstances which might give rise to a Claim being made against any Insured? ☐ Yes ☐ No If Yes, attach details.

Have any Loss payments been made on behalf of any Insured under any employment practices liability policy or similar insurance or endorsement? ☐ Yes ☐ No If Yes, attach details.

Section 8: PRIOR KNOWLEDGE/REPRESENTATION

IT IS IMPORTANT THAT YOU FILL IN THE BLANK IN THIS PARAGRAPH. No person proposed for coverage is aware of anyfacts or circumstances which he or she has reason to suppose might give rise to a future Claim that would fall within the scope of proposed coverage,except
☐ None or It is agreed that if such facts or circumstances exist, whether or not disclosed, any Claim arising from them is excluded from this proposed coverage.

THE CIA

FRAUD STATEMENTS

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FRAUD NOTICE

GENERAL STATEMENT: Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and [NY: substantial] civil penalties. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN, and VA, insurance benefits may also be denied)

APPLICABLE IN COLORADO: 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 of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN THE DISTRICT OF COLUMBIA: 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.

APPLICABLE IN FLORDIA: 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.

APPLICABLE IN HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT: Any person who knowingly and with intent to defraud any insurance company or another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

APPLICABLE IN MINNESOTA: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA: 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.

APPLICABLE IN WASHINGTON: 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.

I understand that the insurance company, in determining in whether to provide insurance coverage, will rely on the information contained in this form and all other information submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

Insured Signature:	Date:

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Section 9: ADDITIONAL MATERIALS NEEDED

As part of this Application, please attach the following (where applicable):

1. Employment Application 2. Employee Grievance Procedures 3. Employee Handbook/Manual
4. EEO and Anti-Discrimination Policy Statement 5. Anti-Harassment Policy Statement
6. EE0-1 Report for Last Calendar Year

IMPORTANT INFORMATION The submitting of this Application does not obligate the Insurer to issue a coverage section. You will be advised if your Application for coverage is accepted.

FALSE INFORMATION Any person who, knowingly and with the intent to defraud any insurance company or other person, files any Application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

MATERIAL CHANGE Signing this Application does not bind the Parent Company or the Insurer. If there is any material change in the answers to the questions prior to the policy inception date the Parent Company will notify the Insurer in writing and any outstanding quotation or indication may be modified or withdrawn.

DECLARATION AND SIGNATURE The undersigned declares that to the best of his or her knowledge and belief that the statements set forth herein are true. Although the signing of this Application does not bind the undersigned on behalf of the Parent Company or its' directors, officers or Insured Persons to effect insurance, the undersigned agrees that this Application and its attachments shall be the basis of the contract should a Policy be issued and shall be deemed attached to and shall form part of the Policy. The Insurer is hereby authorized to make any investigation and inquiry in connection with this Application that it deems necessary.

Application must be signed by the Chairman of the Board, President or the Director of Human Resources.

(Chairman of the Board, President/Director of Human Resources) Signature	
Date:	Title:

SAVE APPLICATION