THE MARYLAND COMMERCIAL INSURANCE GROUP
A MEMBER OF THE ZURICH GROUP

APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE COVERAGE NEW YORK

Note: In applying for coverage, you understand that the insurance coverage you are applying for is written on a CLAIMS MADE basis. Only claims which are first made against you and reported to the Company during the Policy Period are covered subject to the policy provisions. The Limits of Liability stated in the Policy are reduced by claim expenses. Claims expenses are also subject to the application of the deductible and the Insured's co-payment percentage. If you have any questions about the coverage, please discuss them with your agent.

GENERAL INFORMATION

PART 1.

Applicant ______________________________

Mailing Address ______________________________

City ______________________ State __________ Zip Code __________

Person To Contact

NAME ______________________ PHONE __________

TITLE ______________________

Producer ______________________ Code __________

Person To Contact

NAME ______________________ PHONE __________

TITLE ______________________

Policy Effective Date __________ Policy Expiration Date __________

Type of Business Organization Corporation ____ Partnership ____ Individual Proprietor ____

Other (specify) ______________________

Year Business Started __________

Insured's State of Domicile __________

Briefly describe the nature of the operations of the Applicant:

____

Is the Applicant a Subsidiary of Another Company? (Y/N) ____

If Yes: Identify Parent: ______________________

Is Directors & Officers Liability Coverage to be separately submitted to Maryland Commercial Insurance Group? (Y/N) ____

The Maryland Commercial Insurance Group is a member of the worldwide Zurich Insurance Group and is comprised of eight property and casualty insurance companies: Maryland Casualty Company, Assurance Company of America, Maine Bonding & Casualty Company, Maryland Insurance Company, Maryland Lloyds, National Standard Insurance Company, Northern Insurance Company of New York, and Valiant Insurance Company.

COVERAGE

PART 2.

Limit of Liability Requested: (Each Claim/Total Policy Period Limit)

$100,000/$100,000 $250,000/$250,000 $500,000/$500,000 $1,000,000/$1,000,000

Deductible requested: (Each Claim)

$5,000 $10,000 $25,000

EMPLOYMENT PRACTICES

PART 3.

Regular Full Time Employees: Employees hired to work at least 35 hours, 5 days per week, 7 hours per day on a regular basis.

Regular Part Time Employees: Employees hired to work less than 35 hours per week on a regular basis. Part time may be eligible for certain other limited benefits as required by law. This includes any seasonal, temporary, contract or leased employees.

Please provide a breakdown based on the following:

State	Full Time Employees	Part Time Employees
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
Total	________	________

For additional states please attach a separate sheet of paper.

PART 4.

Does the Applicant have a Human Resources or Personnel Department? (Y/N)____

If No, who performs human resource functions? What type of additional training is provided to such individual? How often is additional training provided?

____

Please describe the reporting relationship of the HR department or a person(s) performing this function to Senior Management.

____

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PART 5.

Does the Applicant:

1. Use an employment application for all applicants? (Y/N)____
2. Have an implemented anti-sexual harassment policy? (Y/N)____
3. Distribute an employee handbook to all employees? (Y/N)____
4. Have a formal progressive discipline policy? (Y/N)____
5. Have a written procedure for handling employee complaints of discrimination or sexual harassment? (Y/N)____
6. Conduct sensitivity training or other discrimination or sexual harassment prevention education? (Y/N)____
7. Have any government contracts which require an Affirmative Action Plan (AAP)? (Y/N)____
   If Yes, has the Applicant implemented the plan? (Y/N)____
8. Provide regular, written performance evaluations for all employees? (Y/N)____
9. Have a policy accommodating the disabled as required by The Americans with Disabilities Act (ADA)? (Y/N)____
10. Have an Employee Assistance Plan (EAP)? (Y/N)____
11. Require any termination to be reviewed by Human Resource person or legal counsel? (Y/N)____
12. Policy on AIDS/HIV or an assisting employees with life threatening or communicable diseases? (Y/N)____
13. Have "English Language" only rules in effect? (Y/N)____

TESTING

PART 6.

1. Do you use any medical or psychological tests to screen applicants for employment or to promote employees? (Y/N)____
   If Yes, what type of test?
   ____
2. When are the tests conducted? Pre-Job Offer ______ or Post-Job Offer ______

TURNOVER / LAYOFF / DOWNSIZING

PART 7.

1. For each of the past five years, what has been the exact number of employee turnover annually?

______________ ______________ ______________

______________ ______________

2. How many terminations, not including layoffs, RIFS, or downsizings, have occurred within the previous 24 months? Please provide a breakdown of the number of terminations into the following categories:
   a. Voluntary or mutual termination with severance ____________
   b. Voluntary or mutual termination without severance ____________
   c. Involuntary termination - corrective action ____________
   d. Involuntary termination - learning period (failure to meet standards) ____________
3. Does the applicant require any termination to be reviewed by a Human Resource person or legal counsel? (Y/N)____
4. Are releases utilized when mutual terminations with severance occur? (Y/N)____
5. Has the Applicant had within the last 2 years any facility closings, consolidations, layoffs, or staff reductions? (Y/N)____
6. Does the Applicant anticipate within the next 2 years any facility closings, consolidations, layoffs or staff reductions? (Y/N)____

If Yes, Please complete the Downsizing/Layoff Supplemental Information Form.

PRIOR INSURANCE

PART 8.

Does the Applicant carry Employment Practices Liability Insurance now? (Y/N)____

If Yes, describe below:

Insurer ______________________________

Limit of Liability $ ______________________

Deductible Amount $______________

Annual Premium $______________

Inception Date ____________ Expiration Date ____________

Has the prior carrier indicated an intent not to renew? (Y/N)____

If Yes, please explain:

____

____

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PAST CLAIMS ACTIVITIES

PART 9.

In the last 3 years, has the Applicant had to respond to charges or allegations made to the Equal Employment Opportunity Commission, or any similar state or local agency, OR had filed against it any federal or state litigation for:

Wrongful termination? (Y/N)____

Discrimination? (Y/N)____

Harassment, including sexual harassment? (Y/N)____

Retaliatory discharge or treatment against employees? (Y/N)____

If any of the answers to the prior questions is Yes, please complete the Supplemental Claims Information Form.

Are you aware of any facts or circumstances, or any actual or alleged act, error or omission, which may result in claims being made against the Applicant or its employees? (Y/N)____

If Yes, please explain:

____

____

DECLARATIONS AND SIGNATURE

The Applicant warrants to the best of its knowledge and belief that the statements set forth herein are true and include all material information.

The Applicant further warrants that if the information supplied on this application changes between the date of this application and the inception date of the policy period, it will immediately notify the Maryland Commercial Insurance Group of such change. Signing of this application does not bind the Maryland Commercial Insurance Group to offer nor the applicant to accept insurance, but it is agreed that this application and any attachments thereto shall be the basis of the insurance and will be attached and made a part of the policy should a policy be issued.

Signature ______________________________ Title __________________ Date __________________
Principal, Partner, or Officer

The following material must be attached to this application **only if applicable:**

1. Employment Application forms.
2. Employee Handbook/Manual - including copies of Anti-Sexual Harassment Policy, ADA Policy, AIDS/HIV Policy, Family Medical Leave Policy, Termination Policy and Progressive Disciplinary Policies.
3. If the Company is a corporation, the latest annual report or 10K to stockholders.
4. EEO-1 Reports for the past 2 years. (This is a requirement for all employers of 100 or more employees.)
5. Collective Bargaining Agreements - including any applicable arbitration provisions for resolution of employee grievance.
6. Affirmative Action Plan, results of any OFCCP Audit and if applicable, any remedial action plan.

The following statements are required by the regulations of the following state Insurance Departments. It is a requirement of certain states that this signed statement be attached to the policy. Please read the statement applicable for your state and sign where indicated.

CALIFORNIA APPLICANTS: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT SIGNATURE DATE

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.

KENTUCKY 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 FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICANT SIGNATURE DATE

MINNESOTA APPLICANTS: A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

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.

APPLICANT SIGNATURE DATE

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.

APPLICANT SIGNATURE DATE

OHIO APPLICANTS: 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 DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

APPLICANT SIGNATURE DATE

OKLAHOMA APPLICANTS: 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.

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 A PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT SIGNATURE DATE

UTAH APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT UNDERWRITING INFORMATION, FILES OR CAUSES TO BE FILED A FALSE OR FRAUDULENT CLAIM FOR DISABILITY COMPENSATION OR MEDICAL BENEFITS, OR SUBMITS A FALSE OR FRAUDULENT REPORT OR BILLING FOR HEALTH CARE FEES OR OTHER PROFESSIONAL SERVICES IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.