United States Liability Insurance Group
Medical Providers Protection Policy

APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY – PLEASE READ YOUR POLICY CAREFULLY

Defense Costs shall be applied against the Retention.

1. Name of Organization: _____
   Primary Address of Location listed above _____
   If more than 1 location, attach a separate list including address, corporate name and number of employees at each location.

2. Purpose of Organization: _____ Date Organized _____

3. Are there any subsidiaries? Yes ☐ No ☐ If Yes, provide name(s). date established, nature of operation, purpose and percentage of ownership: _____

4. Does the Organization currently carry Employment Practices Liability Insurance? Yes ☐ No ☐
   If Yes, please advise Insurance Co., Limit of Liability, expiring premium and number of years this insurance has been in force.
   _____

5. Total number of employees? Full Time _____ Part Time _____ Temporary ____ Independent Contractors ____ Other ____

6. Percentage of employees with total compensation including salaries, bonuses and commissions:
   Over $50,000 _____% Over $100,00 _____%

7. Does the Organization have a human resource person? Yes ☐ No ☐ If No, advise who handles this function.
   _____

8. Does the Organization have an Employment Handbook? Yes ☐ No ☐
   If Yes, does it include an "Employment at Will" Statement? Yes ☐ No ☐
   If Yes, does it state it is "not a contract of employment"? Yes ☐ No ☐

9. Does the Organization have a written Sexual Harassment guideline? Yes ☐ No ☐

10. Does the Organization have a written Anti-Discrimination (Equal Opportunity Employer) Guideline? Yes ☐ No ☐

If your answer to any of question #'s 8-10 above is "No", please make sure you are in compliance with item #18 of this Application.

11. Has the Organization closed any facilities, downsized, laid off, or reduced staff, or merged or acquired any company in the past 12 months or does the Organization plan to do so in the next 12 months? Yes ☐ No ☐ If Yes, attach details including %.

12. How many employees have been involuntarily terminated or laid off in the past 12 months?_____ 24 months? _____

13. Have the Medical Providers or any Individual Insured ever denied medical or dental services to any person based, in whole or in part, on race, creed, color, sex, sexual orientation, age, national origin, or disability? Yes ☐ No ☐
    If Yes, please advise details on a separate sheet.

14. Have the Medical Providers ever denied medical or dental services or have a policy against providing medical or dental services to an individual because of communicable disease including but not limited to HIV/AIDS? Yes ☐ No ☐
    If Yes, please advise details on a separate sheet.

15. Within the last 5 years has the Organization or any individual proposed for Insurance received any employment related inquiry, complaint or notice of hearing from any Municipal, State or Federal Regulatory Authority or Congressional or Legislative Committee (Including, but not limited to, Equal Employment Opportunity Commission (E.E.O.C.), and State Human Rights cases)?
    Yes ☐ No ☐ If Yes, please explain _____
    _____

16. Within the last 5 years, has any claim been made, or is any claim now pending against the Organization, or any person proposed for insurance in any of the following categories:
    a.) Employment Related Claim of Sexual Harassment, Discrimination, or Wrongful Termination?
    b.) Discrimination against any person other than an employee?
    c.) Sexual Misconduct to a Patient?
    Yes ☐ No ☐ IF YES, ADVISE ON A SEPARATE SHEET DETAILS OF THE CLAIM(S) INCLUDING DEFENSE COSTS INCURRED, DAMAGES PAID, WHETHER IT WAS COVERED BY INSURANCE AND REMEDIAL MEASURES TAKEN TO PREVENT A RECURRENCE OF SUCH CLAIM(S).

17. Is any person proposed for this insurance aware of any fact, circumstance or situation which may result in a claim being made against the Organization or any person proposed for insurance in any of the following categories:
    a.) Employment Related Claim of Sexual Harassment, Discrimination, or Wrongful Termination?
    b.) Discrimination against any person other than an employee?
    c.) Sexual Misconduct to a Patient?
    Yes ☐ No ☐ If Yes, please advise details on a separate sheet.

18. I, _____, as Owner, Principal or Partner of the Organization applying for this insurance, certify that written Anti-Sexual Harassment and Anti-Discrimination Guidelines are already in place or will be implemented within 30 days of the effective date of the policy. The Anti-Discrimination Guideline will state that it applies to employees and applicants for employment in the recruiting, hiring, assignments, compensation, opportunities for advancement, training and discipline. The Anti-Discrimination Guideline will state that it applies to "age, race, creed, color, sex, national origin and disability". Both Guidelines will also advise whom to report violations to and how complaints will be handled. The Anti-Sexual Harassment Guideline will state the Organization's position that it will not tolerate sexual harassment, a definition of what constitutes sexual harassment, what action the company will take if it occurs and whom a victim should contact when a violation occurs. These guidelines will be distributed annually to all employees. I also certify that if there is an employment handbook in place or if one is implemented, it will contain a "contract disclaimer" provision stating the handbook is not to be construed as a contract of employment and an "employment at will" provision stating the Organization or the employee can terminate the relationship at any time, for any reason. The Company will attach an endorsement to the Policy stating that failure to comply with the above shall be grounds for denial of coverage by the Company for employment claims. Sample guidelines may be provided by the Company, upon request.

I further certify that a Third Party Discrimination Guideline is already in place or will be implemented within 30 days of the effective date of the Policy. The Third Party Discrimination Guideline will state that no individual will be refused medical or dental services because of their having contracted a communicable disease (such as HIV/AIDS), or because of their race, creed, color, sex, sexual orientation, age, national origin, disability or Vietnam Veteran status. This Guideline will be distributed annually to all employees. The Company will attach an endorsement to the Policy stating that failure to comply with the above shall be grounds for denial of coverage by the Company for Third Party Discrimination claims. A sample Guideline may be provided by the Company, upon request.

Signature _____ Title _____ Date _____
Owner, Principal or Partner

REQUIRED INFORMATION

A. Completed Application signed and dated by either the Owner, Principal or Partner of the Organization and Human Resource Director (or person handling this function).

B. Copy of Employment Application.

The undersigned warrants that to the best of his/her knowledge and belief the particulars and statements set forth herein are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The Company is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Company not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Company and shall not stop the Company from relying on any statement in this Application. The signing of this Application does not bind the undersigned to purchase the insurance, nor does the review of this Application bind the insurance company to issue a policy. It is understood the Company is relying on this Application in the event the Policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued and it will be attached to and become a part of the policy.

Fraud Statement: 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 such violation.

IF THE PRIMARY ADDRESS OF THE LOCATION LISTED IN ITEM #1 IS IN THE STATE OF NEW YORK, THE STATE OF NEW YORK REQUIRES THAT WE HAVE THE NAMES AND ADDRESS OF YOUR (INSURED'S) AUTHORIZED AGENT OR BROKER.

NAME OF AUTHORIZED AGENT OR BROKER _____

ADDRESS _____

MAIL COMPLETED APPLICATION THROUGH LOCAL AGENT OR BROKER TO:

Signature _____
(Owner, Principal or Partner)

Title _____ Date _____

Signature _____
(Human Resource Manager or person handling this function)

Title _____ Date _____

Quaker Special Risk a division of the Quaker Agency Inc.

(FAX

NAME: Click here to replace text
COMPANY: Click here to replace text
ADDRESS: Click here to replace text
STATE, ZIP: Click here to replace text
DATE: Click here to replace text
NUMBER OF PAGES(incl. Cover): Click here to replace text
* FAX TO: Click here to replace text

PLEASE FAX THIS APPLICATION TO THE OFFICE THAT IS NEAREST YOU.

* Click the link below for a list of our offices and current fax numbers.

http://www.qsr-insurance.com/qsr-fax.html

ADDITIONAL COMMENTS:

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