SHAND MORAHAN & COMPANY, INC.
MARKEL®
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

RENEWAL STATEMENT FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE

Renewal Applicant: _____

Expiring Policy No.: _____

Expiration Date: _____

Risk Id.: _____

1. (a) List any additional Renewal Applicant(s) that are not listed above: _____

   _____

   (b) Are there any Renewal Applicants that are new subsidiaries or affiliates? ..... [ ] Yes [ ] No

   If Yes, provide name(s), nature of operations, percentage ownership by the Renewal Applicant and date formed or created. _____

2. Name, title and e-mail address of the person designated as the representative of the Renewal Applicant to give/receive notices to/from the Company on behalf of all persons and entities proposed for this insurance:

   _____

   (Name) (Title) (Fax) (E-Mail Address)

3. For all Renewal Applicants, provide the following information for all locations within each state. Attach a separate schedule if necessary.

		Number of Directors, Officers, Partners, Employees and Independent Contractors		
State	Number of Locations	Number of Full-time (regular, leased volunteers and temporary)	Independent Contractors	Number of Part-Time (regular, leased, volunteers, temporary and seasonal)

   If Independent Contractors are used, provide details. _____

   _____

4. Provide the total number of employees:

   (a) Involuntarily terminated during the last twelve months: _____

   (b) Voluntarily terminated during the last twelve months: _____

5. Is any Renewal Applicant presently considering or contemplating a change in the nature of business operations, mergers, layoffs, forming any new company, opening any new location or filing for bankruptcy? ..... [ ] Yes [ ] No

   If Yes, provide details. _____

6. Have all Employment Practices Liability claim(s), including all charges filed with the EEOC or state or local agency(ies), and suit(s) that were first made during the last twelve months been reported to Shand Morahan & Company, Inc. or the Company? [ ] None [ ] Yes [ ] No

   If No, provide details. _____

7. During the past twelve months, have there been any changes to any Renewal Applicant's written employment practice policies and procedures? [ ] Yes [ ] No

   If Yes, provide details. _____

8. For any Renewal Applicant, do current liabilities exceed current assets?..... [ ] Yes [ ] No
   If Yes, provide a copy the Renewal Applicant's annual report or audited financial statements for the last year.

THIS RENEWAL STATEMENT SHALL BE THE BASIS OF THE POLICY SHOULD A RENEWAL POLICY BE ISSUED AND WILL BE ATTACHED TO AND BECOME A PART OF THE RENEWAL POLICY. SHAND MORAHAN & COMPANY, INC. AND THE COMPANY WILL HAVE RELIED UPON THIS RENEWAL STATEMENT IN ISSUING ANY POLICY.

FOR THE PURPOSE OF THIS RENEWAL STATEMENT, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS IN THIS RENEWAL STATEMENT ARE TRUE AND COMPLETE. SHAND MORAHAN & COMPANY, INC. OR THE COMPANY IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS RENEWAL STATEMENT. SIGNING THIS RENEWAL STATEMENT DOES NOT BIND THE COMPANY TO PROVIDE OR THE RENEWAL APPLICANT TO PURCHASE THE INSURANCE.

The undersigned hereby authorizes the release of information contained in this application to a loss prevention service provider.

Note: This statement is signed by undersigned authorized agent of the Applicant(s) on behalf of the Applicant(s) and its partners, owners, directors, officers and employees

Must be signed by a human resources director, executive officer, partner or equivalent (within 60 days of the proposed effective date).

Name of Renewal Applicant	Title
Signature of Renewal Applicant	Date

FLORIDA BUSINESS REQUIRED INFORMATION

PRODUCED BY (Insurance Agent or Broker):

Producer Name: _____ Firm Name: _____

Taxpayer ID or Social Security No.: _____ Producer License No.: _____

Agency: _____

Address (No., Street, City, State and ZIP): _____

Notice to Colorado Applicants: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to 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.

Notice to 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.

Notice to New Mexico 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 civil fines and criminal penalties.

Notice to 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.

Notice Ohio Applicants: Any person who, with intent to defraud or knowing that he 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.

Notice to Oklahoma Applicants: 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 false, incomplete or misleading information is guilty of a felony.

Notice to Oregon 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, may be guilty of insurance fraud and may subject the person to criminal and civil penalties.

Notice to Tennessee and Virginia Applicants: 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.

Notice to Applicants (all other states): 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 the person to criminal and civil penalties.

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DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE AND ELECTION FORM

RE:
Risk ID. No.:

You are hereby notified that under the Terrorism Risk Insurance Act of 2002 (the "Act"), effective November 26, 2002, that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, *as defined in Section 102(1) of the Act* ("Terrorism Coverage"): The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property; or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

You should know that Terrorism Coverage required to be offered by the Act for losses caused by certified acts of terrorism is partially reimbursed by the United States under a formula established by federal law. Under this formula, the United States pays 90% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The premium charged for this Terrorism Coverage is provided below and does not include any charges for the portion of loss covered by the federal government under the Act.

SELECTION OR REJECTION OF TERRORISM INSURANCE COVERAGE

PLEASE ENTER "X" IN ONE OF THE BOXES BELOW AND SIGN AND DATE WHERE INDICATED BELOW.

Florida, Georgia and Oklahoma Applicants: Please be advised that in the event a policy is purchased, the policy premium will include a 1% surcharge for Terrorism Coverage unless you elect to decline Terrorism Coverage. You need to enter an "X" below if you wish to decline Terrorism Coverage.

	I hereby elect to purchase the Terrorism Coverage required to be offered under the Act. I understand that my policy premium will include a 3% surcharge for this coverage.
	I decline to purchase the Terrorism Coverage required to be offered under the Act. I understand that my policy will be endorsed to exclude the Terrorism Coverage required to be offered under the Act.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this Disclosure Notice does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance.