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

APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE

NOTICE: THE POLICY FOR WHICH APPLICATION IS MADE APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD" AND REPORTED TO THE COMPANY DURING THE "POLICY PERIOD" OR WITHIN SIXTY DAYS AFTER THE EXPIRATION OF THE "POLICY PERIOD", UNLESS THE EXTENDED REPORTING PERIOD IS EXERCISED. THE LIMITS OF LIABILITY SHALL BE REDUCED BY "CLAIM EXPENSES" AND "CLAIM EXPENSES" SHALL BE APPLIED AGAINST THE DEDUCTIBLE, UNLESS THE POLICY IS AMENDED BY ENDORSEMENT. PLEASE READ THE POLICY CAREFULLY.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. Full name of Applicant: _____

2. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

3. Full description of business operations: _____

4. Date organized (MM/DD/YYYY): _____

5. Have there been any changes in majority ownership since the date organized?..... [ ] Yes [ ] No
If Yes, provide the date Applicant began continuously operating under current ownership: _____

6. Business is a: [ ] corporation [ ] partnership [ ] sole proprietorship [ ] other _____

7. If Applicant is a subsidiary, name of parent company: _____

8. Are there any subsidiaries or affiliated companies?..... [ ] Yes [ ] No

If Yes, provide the following for each subsidiary and affiliated company.

Name	Description of Operations	% of Ownership by Applicant or Affiliate	Date Acquired, Created, or Affiliated	Domicile State

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

_____
(Name) (Title) (Entity)

_____
(Phone) (Fax) (E-Mail Address)

II. EMPLOYEES

1. For all 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. _____

_____

2. Provide the total number of employees:

   (a) Involuntarily terminated: Current Year _____ Last Year _____

   (b) Voluntarily terminated: Current Year _____ Last Year _____

   (c) Whose annual salaries, bonus and commissions were over $100,000 during the last twelve months: _____

3. Do all Applicants currently carry Employment Practices Liability Insurance?..... [ ] Yes [ ] No
   If Yes, provide the following:

Name of Insurer	Limits	Policy Period	Deductible/Retention	Premium	Retro/Prior Acts Date

4. Has any insurer declined, cancelled or nonrenewed any Employment Practice Liability Insurance Policy or any similar insurance on behalf of any person(s) or entity(ies) proposed for this insurance? (Missouri Applicants need not reply.) ..... [ ] Yes [ ] No
   If Yes, provide details._____

   _____

5. During the last three years has any Applicant been involved in, or are they presently considering or contemplating:
   (a) Any merger, consolidation or acquisition? ..... [ ] Yes [ ] No
   (b) Any layoffs, staff reductions, early retirements or office or plant closings? ..... [ ] Yes [ ] No
   (c) Opening any new locations or forming any new companies?..... [ ] Yes [ ] No

   If Yes, to any of the above, provide details. _____

6. Do all Applicants prominently display all of the proper notification posters required by the EEOC? ..... [ ] Yes [ ] No

7. Do all Applicants have a full-time human resource manager or department? ..... [ ] Yes [ ] No

8. Do all Applicants have a written:

   (a) Policy prohibiting discrimination? ..... [ ] Yes [ ] No
   (b) Policy prohibiting sexual harassment? ..... [ ] Yes [ ] No
   (c) Employee handbook? ..... [ ] Yes [ ] No

III. LOSS HISTORY

1. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which might afford grounds for any claim, such as would fall under the proposed insurance?..... [ ] Yes [ ] No
   If Yes, provide details._____

   _____

   _____

2. During the last five years, have there been any claims, demands or charges filed with the EEOC or state agency or any lawsuit against any Applicant at any location, whether filed by current employees, terminated employees or employees not hired? ..... [ ] Yes [ ] No

   If Yes, provide the following information. **For each charge, attach a copy of the charges, the Applicant's response and the dismissal or status.**

Date of claim, demand, charge or law suit	Claimant	Primary Allegation	Losses Paid	Losses Reserved	Legal Expense Paid	Legal Expense Reserved

IV. FINANCIAL INFORMATION

1. Provide the following year-end financial information for the past two years:

   If there is more than one than Applicant, provide consolidated financial information for all Applicants other than affiliated companies. Attached a separate schedule for each affiliate company proposed as an Applicant for this insurance.

Year	Revenues	Net Income/Loss (+/-)	Assets	Equity, Partners Capital or Equivalent (+/-)
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____

2. Presently, do current liabilities exceed current assets for any Applicant?..... [ ] Yes [ ] No
   If Yes, provide a copy the Applicant's annual report or audited financial statements for the last two years.

3. Has any Applicant been the subject of any bankruptcy proceeding or legal or financial reorganization in the last two years or are they considering or contemplating such action? ..... [ ] Yes [ ] No

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

NO FACT, CIRCUMSTANCE OR SITUATION INDICATING THE PROBABILITY OF A CLAIM OR ACTION FOR WHICH COVERAGE MAY BE AFFORDED BY THE PROPOSED INSURANCE IS NOW KNOWN BY ANY PERSON(S) OR ENTITY(IES) PROPOSED FOR THIS INSURANCE OTHER THAN THAT WHICH IS DISCLOSED IN THIS APPLICATION. IT IS AGREED BY ALL CONCERNED THAT IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM SUBSEQUENTLY EMANATING THEREFROM SHALL BE EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

FOR THE PURPOSE OF THIS APPLICATION, 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 APPLICATION AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE. SHAND MORAHAN & COMPANY, INC. OR THE COMPANY IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE COMPANY TO PROVIDE OR THE APPLICANT TO PURCHASE THE INSURANCE.

THIS APPLICATION, INFORMATION SUBMITTED WITH THIS APPLICATION AND ALL PREVIOUS APPLICATIONS AND MATERIAL CHANGES THERETO OF WHICH SHAND MORAHAN & COMPANY, INC. RECEIVES NOTICE IS ON FILE WITH SHAND MORAHAN & COMPANY, INC. AND IS CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY IF ISSUED. SHAND MORAHAN & COMPANY, INC. AND THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION AND ALL SUCH ATTACHMENTS IN ISSUING THE POLICY.

IF THE INFORMATION IN THIS APPLICATION AND ANY ATTACHMENT MATERIALLY CHANGES BETWEEN THE DATE THIS APPLICATION IS SIGNED AND THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL PROMPTLY NOTIFY SHAND MORAHAN & COMPANY, INC., WHO MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION OR AGREEMENT TO BIND COVERAGE.

THE UNDERSIGNED DECLARES THAT THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE UNDERSTAND THAT:

(I) THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD" AND REPORTED TO THE COMPANY DURING THE "POLICY PERIOD" OR WITHIN SIXTY DAYS AFTER THE EXPIRATION DATE OF THE "POLICY PERIOD" UNLESS THE EXTENDED REPORTING PERIOD IS EXERCISED. IF THE EXTENDED REPORTING PERIOD IS EXERCISED, THE POLICY SHALL ALSO APPLY TO "CLAIMS" FIRST MADE DURING THE EXTENDED REPORTING PERIOD AND REPORTED TO THE COMPANY DURING THE EXTENDED REPORTING PERIOD OR WITHIN SIXTY DAYS AFTER THE EXPIRATION OF THE EXTENDED REPORTING PERIOD;

(II) UNLESS AMENDED BY ENDORSEMENT, THE LIMITS OF LIABILITY CONTAINED IN THE POLICY SHALL BE REDUCED, AND MAY BE COMPLETELY EXHAUSTED BY "CLAIM EXPENSES" AND, IN SUCH EVENT, THE COMPANY WILL NOT BE LIABLE FOR "CLAIM EXPENSES" OR THE AMOUNT OF ANY JUDGEMENT OR SETTLEMENT TO THE EXTENT THAT SUCH COSTS EXCEED THE LIMITS OF LIABILITY IN THE POLICY; AND

(III) UNLESS AMENDED BY ENDORSEMENT, "CLAIM EXPENSES" SHALL BE APPLIED AGAINST THE "DEDUCTIBLE".

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

Note: This application 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 Applicant	Title
Signature of 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.