



**This is an application for a claims made and reported policy.**

The following two terms, shown in **bold face** type in this application will have only the meaning indicated below:

**Owned Entity** means any entity:

- A. of which the Named Insured owns, either directly or indirectly, more than 50% of ownership interest and that is listed on the application for this Policy, or
- B. that is a newly acquired entity.

**Management or Supervisory Employee** means any:

- A. owner of the Named Insured or any **Owned Entity** which is a sole proprietorship;
- B. of the following personnel of the Named Insured or any **Owned Entity**: officers, directors, members of the Board of Managers or management committee members, supervisory or managing partners of the firm, in-house counsel, risk manager, or any person performing the human resource management function.

Name of Firm in I.A. will become Named Insured if a policy is issued.

**I. General Information**

A. Name of Firm: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Firm Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Date practice established? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

B. Contact person: Name \_\_\_\_\_ Title \_\_\_\_\_

Contact Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Yes, I would like to receive the free AICPA Insurance Programs e-newsletter. The e-newsletter offers Risk Management alerts, new information on products and Program sponsored CPA Events. My e-mail address is noted above.

Coverage applies to the firm named above and any **Owned Entities**. Coverage for **Owned Entities** can be excluded at the firm's request. All questions in this application pertain to the firm named above and any **Owned Entities**.

C. List all locations, branch offices and **Owned Entity** locations by city and state (include number of employees at each location). Please use a separate addendum.

D. Total Owner and Employee Compensation (All Locations): \$ \_\_\_\_\_ for 12 months ended \_\_\_\_ / \_\_\_\_  
(Mo/Yr)

Was the firm's net income positive in the most recent fiscal year? .....  Yes  No  
If answer is no, please explain in an attachment when you anticipate net income will be positive.

E. Has the firm ever purchased Employment Practices Liability (EPL) Insurance before, whether stand alone or attached to other coverages? .....  Yes  No

Policy Years	Renewal Date	Carrier	Limit	Deductible	Premium
_____	_____	_____	_____	_____	_____

F. Has your EPL insurance ever been cancelled or non-renewed other than for non-payment of premium?  Yes  No  
If Yes, please provide details on a separate sheet. This question is not applicable to Missouri residents.





D. Does the firm publish an employee handbook? . . . . .  Yes  No

**If Yes, attach a copy and answer the following:**

1. Is it distributed to all employees? . . . . .  Yes  No

2. Do employees sign acknowledging that they received it? . . . . .  Yes  No

3. Date current handbook was last reviewed/updated: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. Date of next review/update: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

5. Is this review/update done by legal counsel experienced in employment law? . . . . .  Yes  No

6. If not, who does the review/update? \_\_\_\_\_

E. If your firm publishes an employee handbook, does it contain policies on the following:

1. Sexual Harassment? . . . . .  Yes  No If Yes, is it distributed annually to all employees?  Yes  No

2. Equal Employment Opportunity? . . . . .  Yes  No If Yes, does it list protected classes?  Yes  No

If Yes, does it use omnibus wording: "including all classes protected by federal, state or local law"?  Yes  No

3. The Americans with Disabilities Act? . . . . .  Yes  No

4. Open Door for complaints? . . . . .  Yes  No

5. "At-will" wording? . . . . .  Yes  No

6. Family & Medical Leave Act? . . . . .  Yes  No

7. Separate Pregnancy Leave? . . . . .  Yes  No

8. Substance Abuse? . . . . .  Yes  No

F. Does the firm provide regular, written performance evaluations for most employees? . . . . .  Yes  No

G. Does the firm have written job descriptions for most jobs? . . . . .  Yes  No

H. Does the firm provide employees with a "hotline" phone number in order to register complaints? . .  Yes  No

**If Yes, please attach information regarding the "hotline."**

I. Who of the following must review terminations prior to any action being taken? Check (✓) all that apply:

1. Managing Partner or Officer \_\_\_\_\_ 2. HR Manager or person in charge of HR \_\_\_\_\_

3. Outside legal counsel experienced in employment law \_\_\_\_\_ 4. **Other, explain.** \_\_\_\_\_

J. Does the firm regularly consult with legal counsel who specializes in employment law to discuss employee-employer relation issues? . . . . .  Yes  No

If Yes to I.3. or J., who is this employment law counsel?

Name \_\_\_\_\_ Firm \_\_\_\_\_

City \_\_\_\_\_ Phone No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**V. Loss/Claim History**

A. In the past five years, has the firm had any wrongful termination, discrimination or harassment (sexual or non-sexual) claims or demands (whether insured or not and whether or not any loss has been paid) including any EEOC or similar federal, state or local administrative filings or charges made against the firm, any **Owned Entities**, predecessor firm, or any personnel of the aforementioned? (This should include third party claims made by non-employees). . . . .  Yes  No

1. If the firm's response to question A. is "Yes", please indicate the total number of claims and/or demands in the past five years: \_\_\_\_\_.

A Supplemental Claim Form must be completed for each claim or demand. The number of Supplemental Claim Forms attached must match the total number of claims and/or incidents indicated in question A.1.

B. Is any **Management or Supervisory Employee** aware of any fact, incident, or circumstance which may result in a claim being made against the firm, firm employees, any **Owned Entities** or predecessor firm? For example, but not by way of limitation, we consider it reasonable for you to foresee that a claim may be brought against the firm if a person:

- Makes a formal complaint to a supervisory employee of discrimination, harassment or unfair employment practices;
- Threatens to hire an attorney;
- Asks for a severance package in excess of what is being offered;

- Complains of discrimination, harassment, failure to promote or unfair treatment;
  - Complains of a failure to accommodate under The Americans With Disabilities Act or Family Medical Leave Act.
- If any **management or supervisory employee** is aware of any fact, incident or circumstance as described above please answer “Yes” here and disclose the facts, incidents or circumstances on a separate addendum. This should include third party potential claims by non-employees. Anything that is disclosed or should have been disclosed is excluded from coverage: . . . . .  Yes  No

**VI. Coverage Selection**

Indicate below your desired coverage options:

A. Limits of Liability:  \$100,000  \$250,000  \$500,000  \$1,000,000  \$2,000,000  Other \_\_\_\_\_

**Attention New York Residents:**

THIS IS A CLAIMS MADE POLICY WHICH INCLUDES DEFENSE COSTS WITHIN THE COVERAGE LIMITS. PLEASE READ CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.

B. Per Claim Deductible:  \$2,500 (5 or less employees)  
 \$5,000  \$10,000  \$15,000  \$25,000  \$50,000  Other \_\_\_\_\_

C. Claim Expenses:  Claim expenses reduce limits of liability  Claim expenses in addition to limits of liability

D. Desired Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

The Applicant Firm warrants on its behalf and on behalf of all **Management and Supervisory Employees** and **Owned Entities** that after full investigation and inquiry the statements set forth herein are true and include all material information.

The Applicant Firm further warrants on its behalf and on behalf of all **Management and Supervisory Employees** that if the information supplied on this application changes between the date of this application and the inception date of the policy, it will immediately notify CPA EmployerGard through the producing broker of such change. Signing of this application does not bind Continental Casualty Company to offer nor the Applicant Firm to accept insurance, but it is agreed that this application (facsimile or copy of original) shall be the basis of the insurance and will be attached to and made a part of the policy should a policy be issued. If a facsimile or copy is submitted for attachment to the policy, then the Applicant Firm warrants that the facsimile or copy is a true and current duplicate of the original. It is also acknowledged that the information in this application has been verified by the individual in charge of Human Resources.

**Please attach each of the following, if they exist:**

- Provide details to all “yes” answers, when applicable, by attachment;
- The most recent Employee Handbook or Employee Policy Manual;
- Employment Application Form(s);
- Supplemental Claim Form(s).

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE 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 may be subject to civil fines and criminal penalties. (For New York residents only: 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.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

Signature of Partner or Officer of Applicant Firm	Title	Date



# CPA EmployerGard Supplemental Claim Form

This form is to be completed if any question in Section V.A. of the CPA EmployerGard Application is answered "Yes". Please complete a separate form for each claim or incident and answer all questions fully. Prior to attaching this form to the application, a principal, partner or officer of the applicant firm must sign and date this form.

1. Name of Firm Applicant: \_\_\_\_\_
2. Name of individual(s) in firm who are implicated in the allegations:
 

Defendant: _____	Title: _____
Defendant: _____	Title: _____
Defendant: _____	Title: _____
3. Name of individual raising allegations (Plaintiff): \_\_\_\_\_  
 Relationship to Applicant Firm: \_\_\_\_\_
4. Date of alleged wrongful employment practice or third party wrongful act: \_\_\_\_\_
5. Date Firm became aware of alleged wrongful employment practice or third party wrongful act: \_\_\_\_\_
6. How did Firm become aware?
  - a) \_\_\_ Verbal complaint from employee or Third Party
  - b) \_\_\_ Written notice from employee (Third Party) or employee's (Third Party) attorney
  - c) \_\_\_ Verbal/written notice from someone else other than involved employee or Third Party
  - d) \_\_\_ Filing with state agency
  - e) \_\_\_ Filing with EEOC
  - f) \_\_\_ Receipt of lawsuit
  - g) \_\_\_ Other (please detail) \_\_\_\_\_
7. Name of insurer claim reported to (if any): \_\_\_\_\_
8. Has an attorney been involved? \_\_\_\_\_ If yes, name of attorney & law firm: \_\_\_\_\_

Does attorney specialize in Employment Practice Liability litigation? . . . . .  Yes  No

9. Present status of claim/incident: \_\_\_\_\_ Pending \_\_\_\_\_ Closed
10. If pending, is employee demanding a settlement amount?  Yes  No      What is the amount? \$ \_\_\_\_\_  
 Has Firm Applicant offered a settlement amount?  Yes  No      What is the amount? \$ \_\_\_\_\_  
 What legal expenses have been incurred to date: \$ \_\_\_\_\_
11. If closed, date closed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Total Damages/Settlements Paid: \$ \_\_\_\_\_  
 Total Defense Expenses Paid: \$ \_\_\_\_\_
12. If EEOC/State Agency filing:
  - a. Has right to sue letter been issued? . . .  Yes  No    If yes, Date issued: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Date right to sue expires (or did expire): \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  - b. Has determination of fault been decided? . . .  Yes  No  
 If yes, what was determination? \_\_\_\_\_
13. Detailed description of employee's claim/incident and Applicant Firm's response (attach separate sheet, if necessary).  
 \_\_\_\_\_  
 \_\_\_\_\_

14. What steps have been taken to prevent similar claim/incident? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
15. If claim/incident was Sexual Harassment, has the alleged perpetrator been disciplined or terminated? Please explain.  
 \_\_\_\_\_  
 \_\_\_\_\_

**I understand information submitted herein becomes a part of my CPA EmployerGard Application and is subject to the same warranty and conditions.**

Signature of Partner or Officer of Applicant Firm	Title	Date

# CONTINENTAL CASUALTY COMPANY

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## EMPLOYMENT PRACTICES LIABILITY POLICY

### APPLICATION ADDENDUM – VIRGINIA

The Application is amended by the addition of the following:

The Applicant Firm represents on its behalf and on behalf of all **Management** and **Supervisory Employees** and **Owned Entities** that after full investigation and inquiry the statements set forth herein are true and include all material information.

The Applicant Firm further represents on its behalf and on behalf of all **Management** and **Supervisory Employees** that if the information supplied on this application changes between the date of this application and the inception date of the policy, it will immediately notify CPA EmployerGard through the producing broker of such change. Signing of this application does not bind Continental Casualty Company to offer nor the Applicant Firm to accept insurance, but it is agreed that this application (facsimile or copy of original) shall be the basis of insurance and will be attached to and made part of the policy should the policy be issued. If a facsimile copy is submitted for attachment to the policy, then the Applicant Firm represents that the facsimile or copy is a true and current duplicate of the original. It is also acknowledged that the information in this application has been verified by the individual in charge of Human Resources.

**FRAUD NOTICE: FOR VIRGINIA RESIDENTS ONLY:** 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.

The Supplemental Claim Form is amended as follows:

I understand information submitted herein becomes a part of my CPA EmployerGard Application and is subject to the same representations and conditions.