



335 Commerce Drive, Crystal Lake, IL 60014

SUA Management Liability Application

Please fully answer all questions and submit all requested information. Terms appearing in bold face in this **Application** are defined in the Policy and have the same meaning in this **Application** as in the Policy. If you do not have a copy of the Policy, please request it from your agent or broker. This **Application**, including all materials submitted herewith, shall be held in confidence.

I. ORGANIZATIONAL INFORMATION:

Applicant Name:		Years in Business	
Principal Address:			
Primary Business Activity:			
Business Organization:	Corporation ___ Partnership ___ Limited Liability Corporation ___ Other ___		

If Applicant is a subsidiary of another company, please provide the name of the Parent Company:

FINANCIAL DATA:

Total Assets: \$	Current Assets: \$	Annual Revenues: \$
Total Liabilities: \$	Current Liabilities: \$	Net income/loss: \$
Negative cash flow? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how much? \$	Debt:

Has the Applicant received a going concern opinion from an auditor? Yes No

II. COVERAGE REQUESTED/OTHER INSURANCE INFORMATION:

	D&O	EPL	Fiduciary	E&O	Fidel/Crime
Current:					
Limit/Retention					
Premium					
Insurer					
Policy Period					
Requested:					
Limit/Retention					
Effective Date					

III. EMPLOYMENT PRACTICES LIABILITY COVERAGE *Please complete only if applying for this coverage:*

A. Does the Applicant have a full time Human Resources Department Manager? Yes No
 Human Resources Manager contact information:

Name:	Phone:	Email:
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B. Total number of **Employees** of Applicant including all **Subsidiaries** and all leased and seasonal employees and independent contractors:

	Current Year	1 Year Ago
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Full Time:		
Part Time:		
Seasonal:		
Independent contractors:		
Temporary employees:		
Terminated: (involuntary)		
Resigned: (voluntary)		
Layoffs:		

C. How many employees are union members? _____

D. Number of employees that are in the following salary ranges (salary includes bonuses and commissions):

\$50,000 or less:	\$100,000 - \$250,000:
\$50,000 - \$100,000:	\$250,000 and above:

E. Locations of Applicant by state or country (if foreign) and number of employees for each (attach schedule if necessary):

State or Country	# of Employees	# of locations		State or Country	# of Employees	# of locations

F. Does the Applicant have an employee handbook?

Yes No

1. Has the handbook been reviewed by legal counsel in the past 5 years?

Yes No

2. Does the handbook include or does Applicant have written policies and procedures for:

a. Equal Opportunity Employment/Anti-discrimination

Yes No

b. Employment "at will"

Yes No

c. Anti-sexual harassment/Handling complaints of sexual harassment and other discrimination

Yes No

d. Handling other employee grievances or complaints

Yes No

e. ADA accommodations

Yes No

3. Does the Applicant:

a. Review all terminations with human resources or legal counsel?

Yes No

b. Provide training for anti-discrimination or anti-sexual harassment and other written policies?

Yes No

c. Use severance pay/releases for terminations?

Yes No

d. Provide written performance evaluations?

Yes No

G. Is the Applicant in compliance with Title III of the American with Disabilities Act (building and premises requirements)?

Yes No

H. Is the Applicant a Federal Contractor?

Yes No

1. If Yes, does Applicant have an Affirmative Action Plan?

Yes No

2. Has the Applicant been the subject of an OFCCP audit?

Yes No

If Yes, please attach details.

I. Has the Applicant acquired any companies in the past two (2) years?

Yes No

J. With respect to acquired companies, were any employees or officers terminated or do you plan in the next twelve (12) months to terminate any employees or officers?

Yes No

If so, how many? _____

K. Does the Applicant contemplate in the next twelve (12) months any employee layoffs, including anything resulting

from a branch, location, facility, office or subsidiary closing or consolidation? Yes No

L. If during the next twelve (12) months, circumstances of which you are currently unaware make it necessary for you to decrease the number of your Employees by ten percent (10%) or five (5) employees, whichever is greater, through the reorganization, restructuring, reduction in force, downsizing of operations or closure of one or more plants or places of business, do you agree that you will consult with and follow the recommendation of legal counsel experienced in employment law prior to any such downsizing, reorganization, restructuring, reduction in force, change in number of Employees, or closure of one or more plants or places of business operations? Yes No

IV. DIRECTORS AND OFFICERS COVERAGE *Please complete only if applying for this coverage:*

A. Please list all subsidiaries including ownership by percentage:

Subsidiary Name	Applicant's Ownership Percentage
	%
	%

Attach additional page if necessary.

B. Is the Applicant a party to any joint venture arrangements or partnership agreements? Yes No
If Yes, please attach details.

C. Shareholder Information:

Total Number of Shareholders:			
Director/Officer Shareholders:	% Voting Shares Owned:	Other Shareholders owning 5% or more:	% Voting Shares Owned:

D. How many employed lawyers (in-house counsel) does the Applicant employ? _____

E. Has Applicant within the past twelve months completed or agreed to, or does it contemplate in the next twelve months, any of the following:

1. A merger, acquisition, creation, divestiture, or tender offer of or for any entity, plant, office, subsidiary, branch or division?			
Next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Past 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Sale, distribution or divestiture of any assets or stock other than in the ordinary course of business?			
Next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Reorganization or arrangement with creditors under federal or state law?			
Next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Any registration for a public offering or private placement of securities or share repurchase? If Yes, please attach a copy of the Prospectus or other documents.			
Next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has the Applicant had any breach or violation of any debt covenant or loan agreement or any other material contractual obligation?			

Next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the ownership of the Applicant changed in the past year or does the Applicant anticipate a change in ownership?	
Next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has there been any change in the board of directors or senior management?	
Next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

V. FIDUCIARY LIABILITY INSURANCE COVERAGE *Please complete only if applying for this coverage:*

Benefits Manager or Plan Administrator:	Phone:	e-mail:
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A. List all **Plans** for which coverage is requested:

<u>Plan Name</u>	<u>Total Assets</u>	<u>Number of Participants</u>	<u>Type of Plan*</u>	Check if the Plan is not a Qualified Plan	Check only if the Plan has Investments in Employer <u>Securities</u>	Check only if this is not a single employer Plan
				<input type="checkbox"/> Not Qualified	<input type="checkbox"/>	<input type="checkbox"/> Multiemployer
				<input type="checkbox"/> Not Qualified	<input type="checkbox"/>	<input type="checkbox"/> Multiemployer
				<input type="checkbox"/> Not Qualified	<input type="checkbox"/>	<input type="checkbox"/> Multiemployer

*W = Welfare Benefit, DC = Defined Contribution, DB = Defined Benefit, ESOP= Employee Stock ownership Plan, O = Other

Indicate if additional **Plans** are listed on an attachment.

B. Are **Plan** assets managed by an independent investment manager? Yes No
If No, attach details of investment procedures.

- How often is the investment manager's performance reviewed? _____
- Does any **Plan** employ the investment, trustee, actuarial, legal, administrative or benefits consulting services of any outside provider(s)? Yes No

If Yes, attach the name(s) of the organization(s), the service(s) they provide and the **Plan(s)** for which services are provided.

C. Has any **Plan** experienced an event reportable to the PBGC or been the subject of an investigation by the DOL, the IRS or any similar foreign agency in the last three years? Yes No
If Yes, please attach details.

D. Do all **Plans** conform to the provisions of **ERISA** including those regarding eligibility, investments and vesting? Yes No

E. Are all **Plans** reviewed periodically to ensure there are no violations of **ERISA's** rules on party-in-interest or prohibited transactions? Yes No

F. In the past two years, has there been any amendment(s) to any **Plan** that has resulted in or may result in any change or reduction of **Benefits** or are any such amendments contemplated? Yes No
If Yes, attach details of the amendment(s).

G. Has any **Plan** or portion of any **Plan** been sold, transferred or terminated? Yes No
 If Yes, attach the date of sale or termination, whether assets have been fully distributed or reverted to a party other than the **Plan** participants and name of annuity provider if **Benefits** have been secured by annuities and whether the Department of Labor has approved such termination.

H. In the last 24 months, has there been, or is there now under consideration, any merger, acquisition, restructuring or consolidation of or by the Applicant or any of its **Subsidiaries** that has resulted in or may result in **Plan** participants transferring to another **Plan**, company or **Subsidiary** or any merger or termination of a **Plan**? Yes No
 If Yes, attach complete details.

I. **Defined Benefit Plan Funding:**

1. Has an actuary certified that all **Plans** are adequately funded in accordance with **ERISA** or any applicable similar common or statutory law of the United States, Canada or any state or other jurisdiction anywhere in the world? Yes No
 If No, attach complete details including plans for bringing funding to adequate levels.

2. Has any **Plan** received an adverse opinion as to its financial condition by an independent public accountant? Yes No
 If yes, please attach audit.

3. Are there any overdue employer contributions for any **Plan** or has a waiver of contributions been requested? Yes No
 If Yes, attach complete details including the **Plan** name and the amount of any overdue employer contributions for each such **Plan**.

4. Has the Applicant converted any Defined Benefit **Plan** to a cash balance **Plan** within the previous five (5) years or have plans to do so within the next twelve (12) months? Yes No
 If Yes, attach complete details including the date of conversion.

5. Please provide percentage of the plan that is funded: _____

J. Is there **ERISA** fidelity bond coverage currently in force with respect to any **Plan**? Yes No
 If Yes, provide details below:

Insurer:	Expiration Date:
Limit of Liability:	Premium:

VI. **PRIVACY EXTENSION ENHANCEMENT:**

A. Do you restrict employee access to employees' personal information such as social security numbers, account information and health care information? Yes No

B. Are you aware of any actual or alleged fact, circumstance, situation, error or omission or issue which might give rise to a claim against you for invasion or interference with rights of privacy, wrongful disclosure or personal information, or which might otherwise result in a claim against you with regard to the insurance sought? If yes, please give details. Yes No

VII. **LOSS HISTORY:**

A. **Employment Practices Liability:**

1. Have any civil or criminal charges, claims, losses, lawsuits, administrative proceedings, hearings or demands been made against the Applicant or any entity or person proposed for this insurance during the past five (5) years which could fall within the scope of this proposed insurance, whether or not insured, including without limitation any claim involving (a) employees or independent contractors; (b) class action suits or (c) investigations by the Department of Labor, or similar state or foreign agency? Yes No

2. Have any losses, lawsuits, administrative proceedings, hearings or demands been made against the Applicant or any entity or person proposed for this insurance during the past five (5) years alleging violation of any **Wage and Hour Law**? Yes No

B. Third Party Liability:

Has the Applicant or its predecessors ever received a complaint, formal or informal, from a non-employee, such as a customer, client, or prospective customer or client complaining about discrimination or harassment by the Applicant or any employee of the Applicant? Yes No

C. Private Company Liability:

Have any civil or criminal charges, claims, losses, lawsuits, administrative proceedings, hearings or demands been made against the Applicant or any entity or person proposed for this insurance during the past five (5) years which could fall within the scope of this proposed insurance, whether or not insured, including without limitation any claim involving: (a) alleged state or federal copyright, patent, antitrust, fair trade, or securities violations; (b) class actions or derivative suits; or (c) investigations by the SEC, the Department of Labor, or similar state or foreign agency? Yes No

D. Fiduciary Liability:

1. Have any civil or criminal charges, claims, losses, lawsuits, administrative proceedings, hearings or demands been made against the Applicant or any entity or person proposed for this insurance during the past five (5) years which could fall within the scope of this proposed insurance, whether or not insured? Yes No

2. Has any **Plan** ever participated in a voluntary compliance program administered by the IRS or the DOL and has there been any assessment of IRS Closing Agreement Program (CAP) penalties against any **Plan**? Yes No

E. Privacy:

Have any civil or criminal charges, claims, losses, lawsuits, administrative proceedings, hearings or demands been made against the Applicant or any entity or person for invasion or interference with rights of privacy, wrongful disclosure or personal information during the past five (5) years which could fall within the scope of this proposed insurance? Yes No

*If Yes to any question in **Loss History** above, please provide details for each including, as applicable, the type of claim, proceeding or complaint; how it was resolved or whether it is still pending, any amounts paid as defense, settlement or damages and whether any insurance responded to the claim as well as any corrective actions taken as a result of or in response to the claim.*

VIII. REPRESENTATION:

As of the date of this Application, does any Applicant, director, officer or other proposed **Insured** have knowledge or information of any fact, circumstance, situation, event or transaction which may give rise to a claim under this proposed insurance? Yes No

If Yes, please provide details.

It is agreed that any **Claim** based upon or arising out of any claim or fact, circumstance, situation, event or transaction which was or should have been disclosed in the **Representation** above is excluded from coverage under the proposed insurance.

IV. ATTACHMENTS:

Attach the following materials regarding the Applicant:

Latest audited financial statement;

SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED EMPLOYEE OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED EMPLOYEE AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE UNDERWRITER OF SUCH CHANGES, AND THE UNDERWRITER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE. FOR NEW HAMPSHIRE APPLICANTS, THE FOREGOING STATEMENT IS LIMITED TO THE BEST OF THE UNDERSIGNED'S KNOWLEDGE, AFTER REASONABLE INQUIRY. IN MAINE, THE UNDERWRITERS MAY MODIFY BUT MAY NOT WITHDRAW ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF. FOR NORTH CAROLINA, UTAH, AND WISCONSIN APPLICANTS, SUCH APPLICATION MATERIALS ARE PART OF THE POLICY, IF ISSUED, ONLY IF ATTACHED AT ISSUANCE.

AUTHORIZED SIGNATURE OF APPLICANT*
(Must be a principal of the Applicant and a person at risk)

TITLE

Printed Name

Date _____

Effective Date Requested for this Insurance _____