

New Life Agency, Inc. Lloyd's Coverholder

PO Box 5948, Fresno, CA 93755 • Tel (877) 952-5433 (LIFE) • Fax (877) 952-5589

Underwritten by Certain Underwriters at Lloyd's

**APPLICATION EPLIGUARD PLUS PLANS AND D&O INSURANCE
THIS APPLICATION IS FOR A CLAIMS MADE INSURANCE POLICY**

APPLICANT'S INSTRUCTIONS:

1. ALL QUESTIONS MUST BE ANSWERED COMPLETELY; PLEASE TYPE OR PRINT CLEARLY; IF ANY QUESTIONS ARE CONSIDERED "NOT APPLICABLE", PLEASE EXPLAIN WHY.
2. CALCULATE THE PREMIUM FROM THE PREMIUM CHART BELOW.
3. SIGN AND DATE (MUST BE WITHIN 45 DAYS PRIOR TO BINDING) AND RETURN THE COMPLETED APPLICATION TO YOUR BROKER WITH YOUR CHECK FOR THE PREMIUM, PLUS STATE TAXES, POLICY ISSUANCE FEE AND ANY APPLICABLE BROKER FEE.

Section One - Applicant

1) Name of Organization _____
 Address _____

 (City) (State) (Zip Code)

2) **New Life HReSource™ Contacts (please provide 2 contacts):**

(Name)	(Title)	(Phone)	(Fax)	(Email)
(Name)	(Title)	(Phone)	(Fax)	(Email)

3) Organization's Legal Structure: Corporation: _____ Partnership: _____ LLC: _____
 Other (Describe): _____

4) Subsidiaries to be included? *(If Yes, please attach a schedule)* Yes No

5) Nature of operations: _____

6) Date operations commenced under current ownership: _____

7) Number of Employees:
 Full Time: _____ Part Time: _____ Temporary/Seasonal: _____
(Full time employees count as 1 employee. Part time employees count as 1/2 an employee. Seasonal and temporary employees count as 1/3 an employee. Please include independent contractors who work exclusively for the insured on the employee count.)

8) Does the organization currently utilize an employee handbook? Yes No

9) Is the applicant compliant with all mandatory postings as required by law?
(If No, coverage cannot be bound until postings are in place) Yes No

10) Does the organization have an Employment Practices Liability Policy or coverage in force?
If Yes, please indicate: Yes No

The Insurer: _____ Expiration Date: _____
 Limit: _____ Deductible: _____ Premium: _____

For questions 11 through 17, if the answer is "Yes", coverage cannot be bound per the terms and conditions of this program. If you desire an indication outside the program, please provide details for the "Yes" answers.

- 11) Has the Organization reduced staff (voluntary or involuntary) by more than 25% (excluding seasonal employees) in the last 12 months? **Yes** **No**
- 12) Does the organization anticipate closing any facilities, reducing any staff, or laying off any employees (excluding seasonal employees) during the next 12 months? **Yes** **No**
- 13) Has the Organization terminated any senior manager, officer or partner within the last 18 months? **Yes** **No**
- 14) Within the last five years, has any person or entity proposed for this insurance had any employment-related claims/incidents or been named as a defendant or respondent in any regulatory actions including Wage and Hour violations involving a Federal, State or local EEO agency? **Yes** **No**
- 15) Is any person or entity proposed for this insurance aware of any fact, circumstance, or situation, which would indicate the probability of a claim for wrongful employment practice including Wage and Hour violations that may be brought against any proposed insured? **Yes** **No**

Third Party Claims Exposure (please respond if coverage for Third Party claims is desired)

- 16) Within the last five years, has any person or entity proposed for Third Party claims coverage been the subject of or involved in any: litigation, administrative proceeding, demand letter or formal or informal governmental investigation or inquiry? Yes No
- 17) Is any person or entity proposed for Third Party claims coverage aware of any wrongful acts, facts, incidents, or any circumstances which may result in claims being made against you? Yes No

Section Two – Coverage Selection (*Check options desired*):

<u>COVERAGE</u>	<u>LIMIT</u>	<u>SIR</u>	<u>PREMIUM</u>
<input type="checkbox"/> EPLI	<input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000	\$5,000	_____
<input type="checkbox"/> EPLI w/Third Party	<input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000	\$5,000	_____
<input type="checkbox"/> D&O	<input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000	\$5,000	_____

Requested effective date (no backdating): _____

Section Three – Notice to the Applicant

- A. The applicant represents to the best of its knowledge and belief that the statements set forth herein are true and complete.
- B. The applicant agrees that after receipt of the completed application form, underwriters have five working days to either confirm or deny coverage. It is also agreed that this application shall be the basis of insurance and will be attached to and made part of the policy should a policy be issued.
- C. The applicant further represents that if the information supplied on this application changes between the date of the application and the inception date of the policy period, the applicant will immediately notify the underwriter of such change and the underwriter may modify or deny coverage.

Signed: _____ Date: _____

Authorized signature of a Principal or Officer
(Must be signed and dated no more than 45 days prior to binding)

Section four – payment instructions

Return the completed application to your broker with your check or cc payment online for the premium, plus state taxes, policy issuance fee and any applicable broker fee.

Premium for EPLI: <u>(With or without third party)</u>	\$ _____	
Premium for D&O:	\$ _____	
TOTAL Premium:	\$ _____	
CA Taxes & Fees: <u>(on TOTAL Premium)</u>	\$ _____	(3.225% in addition)
Broker fee:	\$ _____	(in addition)
TOTAL PAYMENT	\$ _____	

NOTICE:

- 1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NONADMITTED” OR “SURPLUS LINE” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
- 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
- 4. CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: www.insurance.ca.gov.**
- 5. FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
- 6. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER’S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.”**

Name of Applicant: _____

Title: _____

Date: _____ Signature of Applicant _____

DECLARATION OF NO D&O CLAIMS

COMPANY NAME: _____

It is declared, after inquiry, that within the last five years, no person or entity proposed for Directors & Officers Liability Insurance has been the subject of or been involved in any litigation, administrative proceeding, demand letter, formal or informal governmental investigation or inquiry of a type which might be covered by Directors & Officers Liability Insurance, nor is any person or entity proposed for Directors & Officers Liability Insurance aware of any wrongful acts, facts, incidents, or any circumstances which may result in claims.

Signed: _____
(Owners, CEO, COO or President)

Printed Name: _____

Date: _____

Organizations with claims cannot bind coverage under the terms of this program.

SURPLUS LINE FORM
(To be completed by company license holder)

THIS MUST BE COMPLETED IN FULL IN ORDER TO ISSUE THE POLICY
INFORMATION REGARDING THE FILING AND PAYMENT OF
SURPLUS LINE TAXES

Name of Applicant _____

Surplus Lines License
Number for this filing _____

License Filing State _____

Name of Individual
or Company License Holder _____

Address of License Holder _____

Signature of Person _____

Date _____