Firm:

EPL Insurance Supplement – New York

 E-1

**To be completed by any applicant with “Yes” response to questions 6, 13, 14, 15, 18, 20, 21, 23, 26, or 27 on the standard insurance application, or with interest in coverage for Independent Contractors, or if insufficient room to answer the question on the main portion of the** **application.**

PART I. FIRM INFORMATION

**Question 6**

Complete if the Firm has more than one office location.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Primary Office Per Question #6 of Application | Location #2 | Location #3 |
| Location/Address |  |       |       |
| Name of Partner in Charge |       |       |       |
| Total # of Employees (excluding partners and owners) |       |       |       |
| Percent of Firm’s Total Revenue at Location |       |       |       |

**Question 13**

List Name(s) of additional Partners/Owners.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **% Ownership** | **Title** | **Professional Organization Memberships** | **E-mail Address** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

PART II. FIRM PROFILE

**Question 14**

For office locations, other than location identified as “Primary Office” in Question #6 on the Application. Use additional sheets, if necessary.

***PLEASE DO NOT INCLUDE PARTNERS IN THE FIRM***

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Current Year** | **Prior Year** | **2 Years Ago** |
|  | Location #2 Per Q #6 of E-1 | Location #3 Per Q #6 of E-1 | Location #2 Per Q #6 of E-1 | Location #3 Per Q #6 of E-1 | Location #2 Per Q #6 of E-1 | Location #3 Per Q #6 of E-1 |
| **# of FT Employees** |       |       |       |       |       |       |
| **# of PT Employees** |       |       |       |       |       |       |
| **# of Contract Workers** |       |       |       |       |       |       |
| **# of Leased Workers** |       |       |       |       |       |       |
| **# of Independent Contractor(s)** |       |       |       |       |       |       |
| **Total** |       |       |       |       |       |       |

**Question 15**

Provide details for all independent contractors for which you want coverage for under this insurance for claims brought by such workers. Include number of workers and types of services they perform.

**Question 18**

a. Details of branch or office closings, consolidations, layoffs/staff reductions (greater than 10% of the workforce), mergers or acquisitions within the past 24 months:

b. Details on any of the above anticipated in the next 12 months:

PART III. LOSS HISTORY

**Question 20**

a. Details of any employment-related inquiry, complaint or charge from any municipal, state, or federal regulatory authority or any other governmental entity within the last five years: (Provide date, names of parties, complete description, amount demanded, and amount paid and/or reserved.)

b. Details of any claim, suit, grievance, or demand within the last five years: (Provide date, names of parties, complete description, amount demanded, and amount paid and/or reserved.)

**Question 21**

Details of any facts, incidents, or circumstances which may result in a claim(s) being made against you including names of parties:

PART IV. INSURANCE INFORMATION

**Question 23**

Details of canceled or non-renewed Employment Practices Liability insurance:

Carrier:

Cancellation or Non-renewal Effective Date:

Reason:

PART V. RISK MANAGEMENT PRACTICES

**Question 26**

For tests used to screen employment applicants, to promote employees, or for the purpose of continuing employment, please describe:

* Type of test;
* How the test is administered, (i.e., to all employees or only certain segments of employees). Please detail procedures used; and
* Company creating the test and validation documentation.

**Question 27**

 b. Explain any recommendations made by outside counsel that have not been implemented and reason why not implemented or timeframe estimated to complete implementation.

PART VI. ADDITIONAL INFORMATION

I recognize that information submitted on this supplement becomes a part of my application for coverage and is therefore subject to all of the representations and conditions of that application.

Signature Date