TRAVELERS

Travelers Casualty and Surety Company of America

Health Care Organization Employment Practices Liability Renewal Coverage Application

Claims-Made: The information requested in this Application is for a Claims-Made policy. If issued, the policy will apply only to claims first made during the policy period, or any applicable extended reporting period.

Defense Within Limits: The limits of liability will be reduced, and may be completely exhausted, by amounts paid as defense expenses. The Insurer will not be liable for the amount of any judgment, settlement, or defense expenses incurred after exhaustion of the limit of liability. (For policies issued in New York, the limit of liability may be reduced up to 50% for amounts paid as defense expenses).

IMPORTANT INSTRUCTIONS

This Application will only be accepted for private and non-profit health care organizations. Some of the information in this Application may be prefilled based on previously provided information. Make appropriate changes if necessary.

GENERAL INFORMATION

Name of Applicant:				
Street Address:				
City:		State:	Zip:	
Primary Contact Name and Title:		Telephone Number:		
Email Address:	Web Address:			
Organization Type: ☐ Private ☐ Non-profit		NAICS Code:	Year Established:	Expiring Policy Number:

ORGANIZATION INFORMATION

1. Does the Applicant have direct ownership interest of 50% or more in any entity or have management control over any entity? ☐ Yes ☐ No

If Yes, complete the following:

Name	% Owned	Year Started	Description of Operations	Entity Type*
	%			
	%			
	%			

*Entity Type: FP = For Profit (other than Partnership); NP = Non-Profit; GP = General Partnership; LP = Limited Partnership

To enter more information, attach a separate page to the Application.

*Under the Health Care Organization Employment Practices Liability policy, affiliates, other than Subsidiaries as defined in the policy, are **not** covered unless the Company has agreed to specifically schedule such entities by endorsement.*

EMPLOYEE INFORMATION

Include information for the Applicant and all Subsidiaries.

2. Employee count (include all leased, per diem, seasonal, and temporary employees):
   a. Total full-time employees: _____
   b. Total part-time employees: _____
   c. Total employees in California: _____
   d. Total employees in Illinois: _____

3. Total physicians (include employees, independent contractors, and owners): _____

4. Total natural person independent contractors: _____ ☐ N/A

5. Total employees fired (excluding layoffs) in the past 12 months: _____ ☐ N/A

6. Total number of employees laid off in the past 12 months: _____ ☐ N/A

7. Are any layoffs anticipated in the next 12 months? ☐ Yes ☐ No

Attach an explanation of any layoffs including timing, surrounding circumstances, and number of impacted employees.

HUMAN RESOURCES

8. Do the Applicant and its Subsidiaries have an employee handbook or similar written employment guidelines, policies, and procedures? ☐ Yes ☐ No

9. Do the Applicant and its Subsidiaries consult with employment counsel prior to all terminations? ☐ Yes ☐ No

REQUESTED INSURANCE TERMS/CURRENT INSURANCE INFORMATION

10. Requested Terms:

Limit Requested: $ _____

Retention Requested: $ _____

11. If the Applicant is requesting a limit that is greater than its expiring limit, is the Applicant, any Subsidiary, or any person proposed for this insurance, aware of any circumstance that could reasonably give rise to a claim against them under this Health Care Organization Employment Practices Liability coverage? ☐ Yes ☐ No ☒ N/A

REQUIRED ATTACHMENTS

As part of this Application, provide copies of the documents listed below. Such documents are made a part of this Application, and the Company may elect to obtain requested information from public sources, including the internet.

- Employee handbook, if Applicant has more than 250 employees.
- EEO-1 report, if Applicant has more than 1,000 employees.
- Most recent year-end financial statement, if policy limit requested is greater than $3,000,000.
- Downsizing Supplemental Application, if layoffs are 10% of workforce or impact more than 100 employees.

ORGANIZATIONS NOT ELIGIBLE FOR COVERAGE

Coverage will not be considered for companies involved in whole or in part in paramilitary operations, pornography, adult entertainment, escort services, prostitution, or the manufacturing, distribution, or sale of marijuana.

NOTICE REGARDING COMPENSATION

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Agency Compensation, One Tower Square, Hartford, CT 06183.

FRAUD STATEMENTS – ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company to defraud or attempt 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 to defraud or attempt to defraud the policyholder or claimant regarding a settlement or award payable from insurance proceeds will be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA: 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.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO, AND PENNSYLVANIA: 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 such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company to defraud the company. Penalties include imprisonment, fines, and denial of insurance benefits.

OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

PUERTO RICO: Any person who knowingly and intending to defraud presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, will incur a felony and, upon conviction, will be sanctioned for each violation with the penalty of a fine of not less than $5,000 and not over $10,000, or a fixed term of imprisonment for three years, or both penalties. Should aggravating circumstances be present, the penalty established may be increased to a maximum of five years; if extenuating circumstances are present, it may be reduced to a minimum of two years.

SIGNATURES

The undersigned Authorized Representative represents that to the best of their knowledge and belief, and after reasonable inquiry, the statements provided in response to this Application are true and complete, and may be relied upon by Travelers as the basis for providing insurance. The Applicant will notify Travelers of any material changes to the information provided. Except in North Carolina and Utah, this Application, including any requested or submitted information, will be deemed attached to and form a part of any policy issued.

☐ Electronic Signature and Acceptance – Authorized Representative*

*If electronically submitting this document, electronically sign this form by checking the Electronic Signature and Acceptance box above. By doing so, the Applicant agrees that use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes acceptance and agreement as if signed in writing and has the same force and effect as a signature affixed by hand.

Authorized Representative Signature (Partner, Principal, Officer, Head of Human Resources, or General Counsel): **X**	Authorized Representative Name and Title:	Date *(month/dd/yyyy)*:
Producer Name (required in FL & IA): **X**	State Producer License No (required in FL):	Date *(month/dd/yyyy)*:
Agency:		Agency Phone Number: