

EMPLOYEE BENEFITS LIABILITY SUPPLEMENTAL

1. Named Insured:
-
2. a. List losses and known acts, errors or omissions for the last five years.
-
- b. List known acts, errors or omissions which may result in claims under this insurance.
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3. Was prior coverage carried or written on an (*Check one*): Occurrence Form Claims-Made Form
 N/A Coverage was not previously carried
(If coverage was carried on a claims-made basis, attach copy of the previous claims-made Declarations.)

4. Limits/Coverage	Claims-Made	Each Employee	\$
		Aggregate	\$

Proposed Retroactive Date:
 (The retroactive date is the effective date of your last claims-made policy. If the prior policy was written on an occurrence policy, the retroactive date will be the inception date of this coverage.)
 Date this coverage was first purchased with limits equal to those requested on this application.

5. **Deductible:** \$1,000
6. Number of Employees:

7. Employee benefits provided:
- | | | |
|--|--|--|
| <input type="checkbox"/> Group Life* | <input type="checkbox"/> Group Profit Sharing Plan* | <input type="checkbox"/> Unemployment Insurance* |
| <input type="checkbox"/> Group Accident* | <input type="checkbox"/> Pension Plan* | <input type="checkbox"/> Social Security Benefits* |
| <input type="checkbox"/> Group Health* | <input type="checkbox"/> Stock Subscription Plan* | <input type="checkbox"/> Workers Compensation* |
| <input type="checkbox"/> Group LTD* | <input type="checkbox"/> Other (<i>Explain</i>): _____ | |

(See Coverage Form for benefits covered.)

8. Are Profit Sharing and Stock Subscription plans equally available to all full-time employees? Yes No
(If No, coverage will not apply.)
9. Are Group Life, Group Accident, Group Health, Pension plans, Profit Sharing plans or Stock Subscription plans available to non-employees? Yes No *(If yes, coverage will not apply.)*
10. **Benefit Plan Administration**
- a. Personnel who counsel employees on their benefits are familiar with the details of the programs? Yes No
- b. Are all programs in compliance with COBRA requirements? Yes No
- Explain any No answer:

IMPORTANT NOTICE

DECLARATION

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment.

As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Signature of Applicant

Title

Date

Signature of Producing Agent

Date

Agent Name and Address