MDADVANTAGE INSURANCE COMPANY OF NEW JERSEY

Supreme Advantage®
Application for Employment Practices Liability Insurance

THIS APPLICATION IS FOR A CLAIMS-MADE AND REPORTED POLICY. COVERAGE IS LIMITED TO CLAIMS MADE AGAINST THE INSURED DURING THE TERM OF THE POLICY AND IS SUBJECT TO ALL POLICY PROVISIONS.

Section One – Applicant

1) Name of Organization: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Mailing Address? Please check one: ☐ Office ☐ Billing ☐ Residence

Are you currently insured by MDAdvantage for Medical Professional Liability Insurance? ☐ **Yes** ☐ **No**

If yes, please provide your Policy Number:

Please note: If Applicant is an Entity/Corporation, how many Physicians are with the Group? _____ Please provide Physician information (see last page of Application).

2) Organization's Legal Structure: Corporation: _____ Partnership: _____ LLC: _____

Other (Describe): _____

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

4) Nature of operations: _____

5) Date operations commenced under current ownership: _____

6) Number of Employees (including leased employees and independent contractors):

Full Time: _____ Part Time: _____ Temporary/Seasonal: _____
Independent contractors working exclusively for the Applicant: _____

(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. Independent contractors count as 2/3 an employee.)

7) Does the organization currently utilize an employee handbook? ☐ **Yes** ☐ **No**

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

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

The Insurer: _____ Expiration Date: _____

Limit: _____ Deductible/Retention: _____ Premium: _____

10) Does the organization anticipate in the next 12 months any layoff or reduction in workforce (voluntary or involuntary) by more than 25%, or has the Organization experienced any such layoff or reduction in workforce in the past 12 months? ☐ **Yes** ☐ **No**

11) Does the organization contemplate in the next 12 months any merger, acquisition, divestment, reorganization, closure of a branch or office or any similar event, or has the Organization in the past 12 months been involved in such a merger, acquisition, divestment, reorganization, closure of a branch/office or any similar event? ☐ **Yes** ☐ **No**

12) Has the Organization terminated any senior manager, officer or partner within the last 18 months or anticipate any such terminations in the next 12 months? ☐ **Yes** ☐ **No**

13) Within the last five years, has any person or entity proposed for this insurance had any third party discrimination claims/incidents, or employment-related claims/incidents, or been named as a defendant or respondent in any regulatory actions, including Wage and Hour claims, before a Federal, State or local EEO agency? ☐ **Yes** ☐ **No**

14) Is any person or entity proposed for this insurance aware of any wrongful acts, facts, incidents, situations, or circumstances which would indicate the probability of a wrongful third party claim or a claim for wrongful employment practices, including Wage and Hour claims that may be brought against any proposed insured? ☐ **Yes** ☐ **No**

15) Have you applied for similar coverage with any insurance company, including MDAdvantage, in the past 5 years? ☐ **Yes** ☐ **No**

16) If you answered "Yes" to question 15, were you declined coverage? ☐ **Yes** ☐ **No**

17) If you answered "Yes" to question 15 and were offered coverage, did you decline to accept the offer of coverage? ☐ **Yes** ☐ **No**

18) Have you had similar coverage in force in the past 5 years that was canceled or non-renewed or voluntarily discontinued? ☐ **Yes** ☐ **No**

SUPPLEMENTAL DETAILS REQUIRED:

If "Yes" to question #13 or #14, please provide details including name and title of defendant and claimant, description of the allegation and facts, status of claim, amount of legal expenses incurred, total damages paid and reserved, and steps taken to prevent a similar claim. If complaint is sexual harassment, has the alleged perpetrator been disciplined or terminated?

_____

_____

_____

Please provide details below for any other "Yes" answers to questions 10-18.

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

COVERAGE: ☐ EPLI ☐ EPLI Broad Form including Third Party Coverage

Section Three – Notice to the Applicant

A. The applicant represents that the statements set forth herein are true and complete.

B. The applicant agrees that after receipt of the completed application form, the Company will 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)

Print Name: _____ Title: _____

Physician's Name	**Medical Professional Liability Insurer**	**Policy Number**	**Policy Expiration Date**