

Application Instructions

You have chosen to complete a CPA EmployerGard Renewal Application. Please follow the instructions listed below.

1. Print the application
2. Complete the application
3. Fax the completed application using this fax cover sheet or mail the completed application to the following address:

Mitchell & Mitchell Insurance Agency, Inc.

250 Bel Marin Keys Blvd., #E-1
Novato, CA 94949

If you have any questions, please call one of our representatives at **1-800-562-4272**,
Monday – Friday between 8:00 A.M. and 5:00 P.M. PST.



Mitchell & Mitchell
Insurance Agency, Inc.

Fax

To: Mitchell & Mitchell Insurance Agency, Inc. **From:** _____
Fax: 800-247-5624 **Pages:** _____
Phone: 800-562-4272 **Date:** _____
Re: CPA EmployerGard Renewal Application _____



Renewal Application

This is an application for a claims made and reported policy.

The following two terms, shown in **bold face** type in this application will have only the meaning indicated below:

Owned Entity means any entity:

- A. of which the Named Insured owns, either directly or indirectly, more than 50% of ownership interest and that is listed on the application for this Policy, or
- B. that is a newly acquired entity.

Management or Supervisory Employee means any:

- A. owner of the Named Insured or any **Owned Entity** which is a sole proprietorship;
- B. of the following personnel of the Named Insured or any **Owned Entity**: officers, directors, members of the Board of Managers or management committee members, supervisory or managing partners of the firm, in-house counsel, risk manager, or any person performing the human resource management function.

Name of Firm in I.A. will become Named Insured if a policy is issued.

I. General Information

A. Name of Firm: _____

Address: _____

City: _____ State: _____ Zip: _____

Firm Telephone Number: _____ Fax Number: _____

B. Contact person: Name _____ Title _____

Contact Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Yes, I would like to receive the free AICPA Insurance Programs e-newsletter. The e-newsletter offers Risk Management alerts, new information on products and Program sponsored CPA Events. My e-mail address is noted above.

Coverage applies to the firm named above and any **Owned Entities** listed on this application. Coverage for **Owned Entities** can be excluded at the firm's request. All questions in this application pertain to the firm named above and any **Owned Entities**.

C. List all **Owned Entities**. Please use a separate addendum.

D. List all locations and branch offices by city and state (include number of employees at each location).
Please use a separate addendum.

E. Total Owner and Employee Compensation (All Locations): \$ _____ for 12 months ended ____ / ____
(Mo/Yr)

Was the firm's net income positive in the most recent fiscal year? Yes No
If answer is no, please explain in an attachment when you anticipate net income will be positive.

II. Employees/Equity Owners

A. Current number of employees and equity owners including **Owned Entities**:

Full-time _____ Part-time _____ Temporary/Agency _____ Independent Contractors _____
Seasonal _____ Average number of months seasonal employees engaged _____

B. How many members of the firm are equity owners? _____

- C. How many employees listed above are leased per a leasing agreement? _____
- D. List number of full-time employees and equity owners whose total compensation including commissions/bonus and any other compensation falls within these ranges:
 \$75,000 to \$149,999 _____ \$150,000 to \$249,999 _____ \$250,000 and over _____
- E. Employee Turnover

Time Period	Last 12 Months
Total number of employees at the beginning of the period	1.
Number of employees hired during the period	2.
Number of employees terminated voluntarily during the period	3.
Number of employees terminated involuntarily during the period	4.
Total number of employees at the end of the period	5.

- F. Has the firm had any branch or office closings, consolidations, reduction in the number of partners or equity owners or layoffs affecting 20% or more of the total number of employees within the past 12 months? Yes No
If yes, please provide complete details on a separate sheet.
- G. In the case of downsizing, would or does the firm consult employment law counsel prior to terminating any employee? Yes No
- H. Within the past year has your firm or any **Owned Entity**:
- merged or acquired the business of any sole practitioner, accounting firm or other business entity? Yes No
 - reduced the number of its owners, partners or officers by 50% or more? Yes No
- If Yes to H.1. or H.2., please provide complete details on a separate sheet.**

III. Training of Managers/Supervisors

- A. Has the firm's managers and/or supervisors attended any training programs on employer-employee relations in the past year? Yes No
- B. Did the program include Sexual Harassment Training? Yes No
- C. Was training on Sexual Harassment extended to all employees? Yes No

IV. HR Policies and Procedures

- A. Does the firm have a Human Resources or Personnel Department Manager? Yes No
 If No, who handles this function? Name _____ Title _____
- B. Did the firm implement or update an employment application? Yes No
If Yes, please attach a copy.
- C. Does the firm perform any of the following pre-employment screenings? (Check (✓) if yes)
- Check employment history
 - Check references
 - Check credit
 - Check credentials/licensing
 - Check for criminal record
 - Post-offer drug/alcohol testing: If yes, is it In-house Third Party
- D. Did the firm implement or update an employee handbook? Yes No
If Yes, please attach a copy.
- E. Does the firm provide regular, written performance evaluations for most employees? Yes No
- F. Does the firm have written job descriptions for most jobs? Yes No

G. Who of the following must review terminations prior to any action being taken? Check (✓) all that apply:
 1. Managing Partner or Officer _____ 2. HR Manager or person in charge of HR _____
 3. Outside legal counsel experienced in employment law _____ 4. **Other, explain.** _____

H. Does the firm regularly consult with legal counsel who specializes in employment law to discuss employee-employer relation issues? Yes No
 If Yes to G.3. or H., who is this employment law counsel?
 Name _____ Firm _____
 City _____ Phone No. _____ - _____ - _____

V. Loss/Claim History

A. In the past year, has the firm had any wrongful termination, discrimination or harassment (sexual or non-sexual) claims or demands (whether insured or not and whether or not any loss has been paid) including any EEOC or similar federal, state or local administrative filings or charges made against the firm, any **Owned Entities**, predecessor firm, or any personnel of the aforementioned? (This should include third party claims made by non-employees). Yes No

A Supplemental Incident/Claim Form must be completed for each claim or demand. The number of Supplemental Incident/Claim Forms attached must match the total number of incidents and/or claims indicated in question A.

B. Is any **Management or Supervisory Employee** aware of any fact, incident, or circumstance which may result in a claim being made against the firm, firm employees, any **Owned Entities** or predecessor firm? Yes No
 For example, but not by way of limitation, we consider it reasonable for you to foresee that a claim may be brought against the firm if a person:

- Makes a formal complaint to a supervisory employee of discrimination, harassment or unfair employment practices;
- Threatens to hire an attorney;
- Asks for a severance package in excess of what is being offered;
- Complains of discrimination, harassment, failure to promote or unfair treatment;
- Complains of a failure to accommodate under The Americans With Disabilities Act or Family Medical Leave Act.

If Yes, please attach a completed Incident/Claim form for each fact, incident or circumstance.

VI. Coverage Selection

Indicate below your desired coverage options:

A. Limits of Liability: \$100,000 \$250,000 \$500,000 \$1,000,000 \$2,000,000 Other _____

Attention New York Residents:

THIS IS A CLAIMS MADE POLICY WHICH INCLUDES DEFENSE COSTS WITHIN THE COVERAGE LIMITS.
 PLEASE READ CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.

B. Per Claim Deductible: \$2,500 (5 or less employees)
 \$5,000 \$10,000 \$15,000 \$25,000 \$50,000 Other _____

C. Claim Expenses: Claim expenses reduce limits of liability Claim expenses in addition to limits of liability

The Applicant Firm warrants on its behalf and on behalf of all **Management** and **Supervisory Employees** and **Owned Entities** that after full investigation and inquiry the statements set forth herein are true and include all material information.

The Applicant Firm further warrants on its behalf and on behalf of all **Management** and **Supervisory Employees** that if the information supplied on this application changes between the date of this application and the inception date of the policy, it will immediately notify CPA EmployerGard through the producing broker of such change. Signing of this application does not bind Continental Casualty Company to offer nor the Applicant Firm to accept insurance, but it is agreed that this application (facsimile or copy of original) shall be the basis of the insurance and will be attached to and made a part of the policy should a policy be issued. If a facsimile or copy is submitted for attachment to the policy, then the Applicant Firm warrants that the facsimile or copy is a true and current duplicate of the original. It is also acknowledged that the information in this application has been verified by the individual in charge of Human Resources.

Please attach each of the following, if they exist:

- Provide details to all “yes” answers, when applicable, by attachment;
- Employment Application Form(s) if answered yes to IV. B.;
- The most recent Employee Handbook or Employee Policy Manual if answered yes to IV. D.;

FOR VIRGINIA RESIDENTS ONLY

The Application is amended by the addition of the following:

The Applicant Firm represents on its behalf and on behalf of all **Management** and **Supervisory Employees** and **Owned Entities** that after full investigation and inquiry the statements set forth herein are true and include all material information.

The Applicant Firm further represents on its behalf and on behalf of all **Management** and **Supervisory Employees** that if the information supplied on this application changes between the date of this application and the inception date of the policy, it will immediately notify CPA EmployerGard through the producing broker of such change. Signing of this application does not bind Continental Casualty Company to offer nor the Applicant Firm to accept insurance, but it is agreed that this application (facsimile or copy of original) shall be the basis of insurance and will be attached to and made part of the policy should the policy be issued. If a facsimile copy is submitted for attachment to the policy, then the Applicant Firm represents that the facsimile or copy is a true and current duplicate of the original. It is also acknowledged that the information in this application has been verified by the individual in charge of Human Resources.

FRAUD NOTICE: FOR VIRGINIA RESIDENTS ONLY: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Supplemental Claim Form is amended as follows:

I understand information submitted herein becomes a part of my CPA EmployerGard Application and is subject to the same representations and conditions.

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE 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 may be subject to civil fines and criminal penalties. (For New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

Signature of Partner or Officer of Applicant Firm	Title	Date



CPA EmployerGard Supplemental Incident/Claim Form

This form is to be completed if any question in Section V.A. and/or B. of the CPA EmployerGard Application is answered "Yes". Please complete a separate form for each claim or incident and answer all questions fully. Prior to attaching this form to the application, a principal, partner or officer of the applicant firm must sign and date this form.

1. Name of Firm Applicant: _____
2. Name of individual(s) in firm who are implicated in the allegations:

Defendant: _____	Title: _____
Defendant: _____	Title: _____
Defendant: _____	Title: _____
3. Name of individual raising allegations (Plaintiff): _____
 Relationship to Applicant Firm: _____
4. Date of alleged wrongful employment practice or third party wrongful act: _____
5. Date Firm became aware of alleged wrongful employment practice or third party wrongful act: _____
6. How did Firm become aware?
 - a) ___ Verbal complaint from employee or Third Party
 - b) ___ Written notice from employee (Third Party) or employee's (Third Party) attorney
 - c) ___ Verbal/written notice from someone else other than involved employee or Third Party
 - d) ___ Filing with state agency
 - e) ___ Filing with EEOC
 - f) ___ Receipt of lawsuit
 - g) ___ Other (please detail) _____
7. Name of insurer claim reported to (if any): _____
8. Has an attorney been involved? _____ If yes, name of attorney & law firm: _____

 Does attorney specialize in Employment Practice Liability litigation? Yes No
9. Present status of claim/incident: _____ Pending _____ Closed
10. If pending, is employee demanding a settlement amount? Yes No What is the amount? \$ _____
 Has Firm Applicant offered a settlement amount? Yes No What is the amount? \$ _____
 What legal expenses have been incurred to date: \$ _____
11. If closed, date closed: ____/____/____
 Total Damages/Settlements Paid: \$ _____
 Total Defense Expenses Paid: \$ _____
12. If EEOC/State Agency filing:
 - a. Has right to sue letter been issued? . . . Yes No If yes, Date issued: ____ / ____ / ____
 Date right to sue expires (or did expire): ____ / ____ / ____
 - b. Has determination of fault been decided? . . . Yes No
 If yes, what was determination? _____
13. Detailed description of employee's claim/incident and Applicant Firm's response (attach separate sheet, if necessary).

14. What steps have been taken to prevent similar claim/incident? _____

15. If claim/incident was Sexual Harassment, has the alleged perpetrator been disciplined or terminated? Please explain.

I understand information submitted herein becomes a part of my CPA EmployerGard Application and is subject to the same warranty and conditions.

Signature of Partner or Officer of Applicant Firm	Title	Date