

## STAFFING INDUSTRY INSURANCE APPLICATION

For insurance underwritten by **Zurich American Insurance Company**

**Submission Requirements:**

- Completed, Signed and Dated Application
- Copy of PEO/ASO/VMS Payrolling/Client Services Agreement
- Copy of Employee Handbook or Employee Manual
- 941's – Last 4 Quarters
- Loss Runs – Currently valued from prior carrier 3 years
- Resumes of Principals and/or Managers – New In Business
- ASA Membership Verification (if applicable)

<b>PROPOSED EFFECTIVE DATE:</b>
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### I. APPLICANT INFORMATION

Applicant Name:

**Additional Subsidiaries to be Included for Coverage. Please use separate sheet for listing subsidiaries.**

Street Address:

Mailing Address:

Owner/Contact Name and Title:

Phone No.

Fax No.

E-Mail Address:

Website:

Number of years in business:

Federal Employer ID Number:

Applicant is:  Sole Proprietor  Partnership  LLC  Corporation  Joint Venture  Other:

Is the Applicant involved in any business other than staffing?  Yes  No If Yes, please describe on separate sheet of paper.

GENERAL INFORMATION	Do You Provide	Projections (next 12 months)	Prior Year Actual
<b>A.</b> Corporate Employee Payroll (In House)		\$	\$
<b>B.</b> Number of Corporate Employees (In House)			
<b>C.</b> Contract/Temporary Employee Payroll	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
<b>D.</b> Number of Contract/Temporary Employees			
<b>E.</b> Worksite Employees Payroll (PEO/ASO)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
<b>F.</b> Number of Worksite Employees (PEO/ASO)			
<b>G.</b> Number of Independent Contractors			
<b>H.</b> Independent Contractor Payroll		\$	\$
<b>I.</b> VMS Client Payroll	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
<b>J.</b> Direct Hire Percentage (%) of Total Revenue	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
<b>K.</b> Number of Direct Hire Employee			

**If You Have Contract/Temporary Employee Payroll And/Or Vms Client Payroll, Please Complete This Table.**

Provide percentage of payroll projections for the next 12 months in the appropriate sections below: Total must equal 100%

Type	%	Type	%	Type	%
Administrative/White Collar	%	Drivers & Construction	%	Heavy Industrial	%
Architects & Engineers (without sign-off authority)	%	Financial (Do not include payroll for Accounting Clerks, Bookkeepers, Billing Clerks)	%	IT/Programmers ( Do not include payroll for Data Entry)	%
Attorneys	%	Healthcare (Doctors and Dentists excluded)	%	Light Industrial & Factory	%

II. CORPORATE OVERVIEW SECTION	
1.	Do your employees/company hold any staffing certifications? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list:
2.	Do you have a(an): <input type="checkbox"/> HR Manager—name: <input type="checkbox"/> Risk Manager name: <input type="checkbox"/> None
3.	Are there procedures in place for background checks/screening prospective employees that include:
a.	Personal interview by a member of your staff? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please describe current procedures.
b.	Do the background checks include criminal acts, including any sexual related crimes, or child abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do your employment applications:
a.	Require that the Applicant provide at least one reference? <input type="checkbox"/> Yes <input type="checkbox"/> No
b.	Are Applicant reference(s) checked and documentation maintained? <input type="checkbox"/> Yes <input type="checkbox"/> No
c.	Are signed and dated applications required of all prospective Applicants? <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Is there a written Employee Manual/Employee Handbook? <input type="checkbox"/> Yes <input type="checkbox"/> No
a.	Do you distribute and record receipt of manual to all employees? <input type="checkbox"/> Yes <input type="checkbox"/> No
b.	How often is the Employee Manual updated?
c.	Does the Employee Manual include written procedures addressing: (check all that are applicable):
	<input type="checkbox"/> ADA Accommodation <input type="checkbox"/> Hiring and Firing of Employees
	<input type="checkbox"/> Employee Complaints <input type="checkbox"/> Prohibition of Discrimination
	<input type="checkbox"/> Employment at Will <input type="checkbox"/> Prohibition of Sexual Harassment
	<input type="checkbox"/> Equal Opportunity
6.	a. Is documentation maintained on awareness training of staff regarding employee complaints, sexual harassment and/or abuse and molestation policies? <input type="checkbox"/> Yes <input type="checkbox"/> No
	b. How frequently is awareness training conducted?

### III. LIABILITY COVERAGES

A. Professional Liability/Errors & Omissions Coverage		Quote: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<b>Limits of Liability</b> Each Claim/Aggregate <input type="checkbox"/> \$1,000,000/\$2,000,000 <input type="checkbox"/> Other: /	
	<b>Deductible</b> Each Occurrence. \$	
	Proposed Retroactive Date	
	Entry Date Into Uninterrupted Claims Made Coverage*	
	Was Tail Coverage purchased under any previous policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If Yes, please provide details:	

\*The retroactive date shown on the Applicant's first Claims Made policy. If this is the first Claims Made policy, the date will be the same as the Proposed Retroactive Date. If this is a Renewal, it is the effective date of the first policy issued in the sequence of uninterrupted Claims Made policies.

B. General Liability Coverage		Quote: <input type="checkbox"/> Yes <input type="checkbox"/> No
General Liability (Products/Completed Operations and Personal & Advertising included)	<b>Coverage:</b>	<b>Limits:</b>
	Each Occurrence/Aggregate Limit <input type="checkbox"/> \$1,000,000/\$2,000,000 <input type="checkbox"/> Other: /	
	Damage to Premises Rented To You <input type="checkbox"/> \$100,000 <input type="checkbox"/> Other	
	Medical Expense <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000	
	<b>Deductibles:</b>	
	Bodily Injury/Property Damage combined:	
	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other:	
	Separate Bodily Injury and Property Damage Deductible available upon request.	

C. Stop Gap Coverage (General Liability Required)		Quote: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Coverage</b>	<b>Limits</b>
	Bodily Injury by Accident – Each Accident:	<input type="checkbox"/> \$1,000,000/\$1,000,000/\$1,000,000
	Bodily Injury by Disease – Policy Limit:	<input type="checkbox"/> Other: / /
	Bodily Injury by Disease – Each Employee:	
Total payroll in each monopolistic workers' compensation state:		
North Dakota \$	Ohio \$	Washington \$ Wyoming \$

### III. LIABILITY COVERAGES CONTINUED

#### D. Employee Benefits Liability (EBL) Coverage (General Liability Required)

Quote:  Yes  No

Each Act/Aggregate  \$1,000,000/\$2,000,000  Other: /

Deductible  \$1,000  Other:

Total number of eligible Corporate Employees (In-House):

Total number of eligible Contract/Temporary Employees:

Please note that Self Funded Employee Benefits Plans are not eligible.

#### E. Abusive Acts Coverage (General Liability Required)

Quote:  Yes  No

Do you provide Child Day Care Services on your premise(s)?  Yes  No

Do you place contract employees at:

- Child Day Care Centers
- Schools
- Other facilities where children are present

What is the minimum age requirement for employment?

Limits of Liability Each Claim/Aggregate  \$1,000,000/\$2,000,000  Other: /

Deductible Each Occurrence \$

#### F. Employment Practices Liability Insurance (EPLI) Coverage (Coverage not available monoline.)

Quote:  Yes  No

Limits of Liability Each Claim/Aggregate  \$1,000,000/\$2,000,000  Other: /

Deductible Each Occurrence \$

### IV. HIRED AND NON-OWNED AUTO (HNOA) LIABILITY

#### HNOA Coverage (General Liability Required)

Quote:  Yes  No

If No, please continue to Section V.

Do you obtain MVR's on all employees who drive for clients?  Yes  No

Do you update MVR's every year for all drivers?  Yes  No

Do you provide driver training or evaluation?  Yes  No

Do you place drivers to haul hazardous materials or goods?  Yes  No

Do you place any long haul drivers?  Yes  No

Do you require your placements to be added to client auto policy?  Yes  No

Hired/Borrowed and Non-Owned Auto Liability\*  \$1,000,000 CSL

\*Residents of Illinois, Louisiana and Wisconsin must complete and sign the required Uninsured/Underinsured Motorists Selection/Rejection form attached.

### V. CRIME SECTION

#### Crime Coverage

Quote:  Yes  No

If No, please continue to Section VI.

Insuring Agreement		Limit of Insurance	Deductible
1.	Blanket Employee Dishonesty Coverage	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$
	a. Insured's Coverage for Employees Dishonest Acts	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$
	b. Client's Coverage for Insured's Employees Dishonest Acts	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$
	c. Insured's Legal Liability for Employees Dishonest Acts	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$
	d. Insured's Coverage for Theft of Trade Secrets	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$
2.	Loss Inside Premises Coverage	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$
3.	Loss Outside Premises Coverage	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$
4.	Money Orders and Counterfeit Paper Currency Coverage	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$

Crime section continued on the next page

**V. CRIME SECTION CONTINUED**

5.	Depositors Forgery Coverage	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$
6.	Credit Card Forgery Coverage	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$
7.	Computer Fraud and Funds Transfer Fraud Coverage	<input type="checkbox"/> \$100,000 <input type="checkbox"/> Other \$	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Other \$

**PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:**

A.	How often are audits conducted?	
B.	Who conducts the audits?	
C.	Who reconciles bank accounts?	
D.	Can this individual(s) deposit or withdraw?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E.	Are reconciliations verified by a different source?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F.	Does supporting record accompany all checks to be signed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G.	Is record voided upon check issuance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
H.	Are payroll checks issued in accordance with time sheets?	<input type="checkbox"/> Yes <input type="checkbox"/> No
I.	Is record voided upon check issuance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If No, identify controls used to avoid duplication.	
J.	List the names of all your employee welfare or pension plans to be included:	
K.	Number of Non-employee Trustees:	

**VI. POLICY INFORMATION**

**Policy Information** (Entire table must be completed. If "none", please write none.)

Coverage	Insurance Carrier	Limits of Liability	Deductible	Expiration Date	Retro Date	Annual Premium
Professional Liability/E&O						
General Liability						
Stop Gap						
EBL						
Abusive Acts						
EPLI						
Hired/Non-Owned Auto						
Crime						

**VII. LOSS HISTORY: All questions in this section must be answered.**

1. Has insurance ever been declined or cancelled? (Not required in Missouri, proceed to question 2.)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Prof. Liab E&O    | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Abusive Acts         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> General Liability | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> EPLI                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Stop Gap          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Hired/Non-owned Auto | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> EBL               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Crime                | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If Yes, please describe on separate sheet of paper.

2. Do any of the directors, officers, employees or partners of the Applicant have knowledge or information of any occurrence or circumstance which can reasonably be expected to give rise to a claim?  Yes  No

If Yes, please describe on separate sheet of paper.

**Loss History section continued on the next page**

**VII. LOSS HISTORY CONTINUED: All questions in this section must be answered.**

3. Has the Applicant or any director, officer, employee, or partner of the Applicant ever been the subject of disciplinary action as a result of professional activities?  Yes  No

If Yes, please describe on separate sheet of paper.

4. During the past 5 years has any claim been made against the Applicant or any director, officer, employee or partner of the Applicant for:

Professional Liability Errors & Omissions  Yes  No

General Liability  Yes  No

Stop Gap  Yes  No

Employee Benefits Liability  Yes  No

Abusive Acts  Yes  No

EPLI  Yes  No

Hired and Non-Owned Auto  Yes  No

Crime  Yes  No

**Please attach a list and status of all claims made for any of the above questions which you answered Yes, indicate the date, allegation, loss amount, defense cost and dispositions of each.**

By signing this application the undersigned agrees that after inquiry of all prospective insureds, no person proposed for coverage is aware of any fact or circumstance which reasonably might give rise to a future claim that would fall within the scope of the proposed coverage.

Receipt and review of this application does not bind the insurer to provide this insurance.

It is agreed by the undersigned and the insurer that the particulars and statements made in this application, together with all attachments to this application and any other materials submitted to the insurer (all of which attachments and materials shall be deemed attached to the policy as if physically attached thereto) shall be the representations of the undersigned and the prospective insureds. It is further agreed by the undersigned and the prospective insureds that this policy, if issued, is issued in reliance upon the truth of such representations that are incorporated into and made part of this policy. After inquiry of all prospective insureds, the undersigned represents that the statements set forth in this application and its attachments and other materials submitted to us are true and correct. Signing of this application does not bind the undersigned or the insurer.

If the applicant has concealed or misrepresented any material fact, circumstance or fraud concerning this insurance resulting in deception to us which existed at the time of damage and contributed to such damage, this policy may be cancelled and/or coverage denied as long as the deception was material; was made knowingly with the intent to deceive; was relied and acted upon by the Insurer; and deceived the Insurer to the Insurer's injury.

The undersigned further declares that any event taking place between the date this application was signed and the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any information in this application, will immediately be reported in writing to us and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Completion of this form does not bind coverage. The undersigned's acceptance of the company's quotation is required prior to binding coverage and policy issuance. It is agreed that this application shall be the basis of the contract of insurance should a policy be issued and it will be attached to the policy.

**Fraud Warnings Disclosure**

In **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.

In **Maine**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**STATEMENT FROM APPLICANT**

I hereby represent and confirm that the above information, to the best of my knowledge, is true and correct and further certify that I have read all of the questions and answers of these applications.

**Signature:** \_\_\_\_\_  
Authorized Applicant Representative

**Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_  
Agent

**Date:** \_\_\_\_\_

**Agent License #** \_\_\_\_\_  
Required in the State of Florida