



EPACK for A&E Firms – State of Louisiana

For private companies with up to 250 employees and less than \$50 million in assets

<input type="checkbox"/> New Application		Schinnerer Use Only	

INSTRUCTIONS FOR COMPLETING THIS APPLICATION: Please read this application carefully. Complete and submit all requested information and attachments for those Coverage Parts you have checked (X) below. Note: The Applicant must complete Part I and Part V of this application. All information and all submitted materials shall be held in confidence. The Applicant is applying for the following coverages and has completed Parts I, V, and the following sections of this application:

<input type="checkbox"/> Directors & Officers Liability – Part II	<input type="checkbox"/> Employment Practices Liability – Part III
<input type="checkbox"/> Entity Liability (Privately-held Companies Only) – Part II	<input type="checkbox"/> Fiduciary Liability – Part IV

NOTICE: With respect to all coverage parts, the policy you are applying for is a claims-made policy, and subject to its provisions, applies only to any claim first made during the policy period. NO coverage exists for claims first made after the end of the policy period unless, and to the extent, the extended reporting period applies. Defense costs, as well as any losses as defined in each applicable coverage part, reduce the limit of liability and are subject to the retention. Please review the policy carefully and discuss the coverage with your insurance agent or broker.

PART I - GENERAL QUESTIONS (must be completed by Applicant)

I. GENERAL INFORMATION:

1A. The Applicant to be named in Item 1 of the Declarations (the Named Insured):

1B. Street Address (no P.O. box):

City:			Contact Email:	
State:	Zip:	County:	Phone:	Fax:

Website address:

II. BACKGROUND INFORMATION

1. Proposed effective date of coverage being applied for:

2. Officer designated to receive correspondence and notices from the Insurer:

Name: _____ Title: _____

3A. Business Type:

<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> LLC	<input type="checkbox"/> Other:
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3B. Years in Business: _____ SIC Code: _____ # of Locations: _____ Foreign Parent: Yes No

4. During the last 18 months, has the Applicant or any Subsidiary been involved in any:

A. Merger, consolidation, acquisition, tender offer, or divestment of stock? Yes No

B. Layoffs, staff reductions, or facility closings? Yes No

C. Material changes in the nature of operations? Yes No

D. Senior management changes? Yes No

If yes to any of the above, please provide details:

5. During the next 12 months, does the Applicant or any Subsidiary:

A. Plan on transacting any mergers or acquisitions, where such merger or acquisition would involve more than 50% of the total assets of the Applicant? Yes No

B. Anticipate any changes in the nature or size of the Applicants business? Yes No

C. Expect any layoffs, staff reductions or facility closings? Yes No

If yes to any of the above, please provide details:

6. Since the passing of Sarbanes-Oxley Act, has the Applicant and all Subsidiaries adopted corporate governance standards as defined by the provisions of Sarbanes-Oxley? Yes No

III. FINANCIAL INFORMATION

1. As of the most recent fiscal year-end, please provide the following information for Applicant and Subsidiaries:

A. Total Assets: \$ D. Total Equity: \$

B. Long Term Debts: \$ E. Net Income: \$

C. Revenues: \$

2. Within the last 24 months, has the Applicant's or any Subsidiaries' outside auditors:

A. Stated that there are any weaknesses in the Applicant's or any Subsidiaries' system of internal controls? Yes No

B. Rendered a "going concern" opinion? Yes No

IV. EXPIRING COVERAGE INFORMATION

Please complete the following for those coverages you currently have or previously had insurance coverage for:

Coverage	Limit	Retention	Coverage Trigger Date*	Premium	Carrier	Expiration Date
D&O	\$	\$		\$		
Entity Liability	\$	\$		\$		
EPL	\$	\$		\$		
Fiduciary Liability	\$	\$		\$		
MPL	\$	\$		\$		
General Liability	\$	\$		\$		

*Coverage Trigger Date means the "prior & pending litigation date", the "prior acts date" or "retroactive date" shown on the current policy declarations page.

V. CLAIMS INFORMATION

1. Has any claim or notice of potential claim been given to the carrier under any of the above coverages? Y N
If yes, please attach details.

2. Has the carrier under any of the coverages listed above indicated an intent not to offer renewal terms? Y N

3. Within the last 3 years, has the Applicant, any Subsidiary, or any person associated with such entities for whom this insurance is being sought, been the subject of or involved in any claim, written demand, notice, proceeding, or litigation alleging:

A. Anti-trust, copyright, or patent violation? Y N

B. Violations of any federal or state securities laws or regulations? Y N

C. Discriminatory practice violation or litigation? Y N

D. Violation of the Employee Retirement Income Security Act of 1974, as amended, or any similar law? Y N

E. Negligence in providing professional services? Y N

F. Deceptive trade practices or consumer fraud? Y N

4. Within the last 3 years, has any Director or Officer been involved in any litigation concerning any business venture or entity? Y N

5. Within the last 3 years, has the Applicant, any Subsidiary, or any person associated with such entities for whom this insurance is being sought been the subject of disciplinary action by a regulatory agency or associations? Y N

6. Within the last 3 years, has the Applicant, or any Subsidiary or any person associated with such entities for whom this insurance is being sought been the subject of action where a license was revoked or suspended? Y N

B. Action where a license was revoked or suspended? Y N

If yes to any of the above, please attach details.

NOTICE

Providing information about a claim or potential claim in response to any question in any Part of this Application does not create coverage for such claim or potential claim. Applicant's failure to report to its current insurance company any claim made against it during the current policy term, or to report any act, omission, or circumstance which Applicant is aware of which may give rise to a claim, before the expiration of the current policy may create a lack of coverage.

PART II – DIRECTORS & OFFICERS LIABILITY (to be completed only if Applicant is seeking D&O Liability Coverage)

1. If an Applicant is privately held or is an LLC, please complete the following:

A. Total number of common shares outstanding:

B. Total number of common shareholders:

C. Total number of common shares owned by Directors & Officers of the Applicant:

2. Within the last 18 months, has the Applicant or any Subsidiary transacted or attempted:

A. A private debt or equity offering of securities? Y N

B. A public debt or equity offering of securities? Y N

If yes to any of the above, please provide details:

3. Within the next 12 months, does the Applicant or an Subsidiary anticipate any:

A. A private debt or equity offering of securities? Y N

B. A public debt or equity offering of securities? Y N

If yes to any of the above, please provide details:

A. A private debt or equity offering of securities? Y N

B. A public debt or equity offering of securities? Y N

If yes to any of the above, please provide details:

4. Does any shareholder own (directly or beneficially) five (5) percent or more of the common shares outstanding? If yes, please complete chart below. <input type="checkbox"/> Y <input type="checkbox"/> N		
Shareholder Name	Percentage of Ownership	Director/Officer?
1.	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please attach the following for the Applicant: If you are requesting policy limits over \$1M, or your Company's asset size is over \$50M please attach most recent audited financial statement.		
PART III – EMPLOYMENT PRACTICES LIABILITY (To be completed only if Applicant is seeking EPL Coverage)		
1. Applicant Employee information:		
A. What is the Applicant's and all Subsidiaries' combined current total number of full-time employees?		
Part-time and seasonal employees?		
Independent contractors?		
Do you want independent contractors covered under the policy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
B. How many such employees are highly-compensated individuals? (<i>\$100,000 or more per year</i>)		
C. Of the current total, how many are in the following jurisdictions?		
California:		
Outside the U.S.:		
D. What was the Applicant's and all Subsidiaries' total number of employees 1 year ago?		
E. What is the percentage of such employees that have turned over in the past year?		
F. How many of such employees have been terminated over the past 3 months?		
2. During the last 3 years, has the Applicant or any Subsidiary been involved in any administrative proceeding before:		
A. The Equal Employment Opportunity Commission? <input type="checkbox"/> Yes <input type="checkbox"/> No		
B. The U.S. Department of Labor, including the Office of Federal Contract Compliance Program (OFCCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
C. Any state or local government agency whose purpose is to address employment-related claims? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes to any of the above, please attach details.		
3. Is the Applicant or any Subsidiary a Federal Contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the required Affirmative Action Plan in place? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Do the Applicant and all Subsidiaries have written guidelines or procedures for addressing human resource personnel management in the following areas:		
A. Discrimination? <input type="checkbox"/> Yes <input type="checkbox"/> No		
B. Employee at will statement and employee contract disclaimer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
C. Sexual harassment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
D. Employee grievances or complaints? <input type="checkbox"/> Yes <input type="checkbox"/> No		
E. Employee terminations/hiring? <input type="checkbox"/> Yes <input type="checkbox"/> No		
F. Accommodating the disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		
G. Discipline? <input type="checkbox"/> Yes <input type="checkbox"/> No		
H. Orientation of all new employees? <input type="checkbox"/> Yes <input type="checkbox"/> No		
I. Employment evaluations? <input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Do the Applicant and all Subsidiaries distribute written guidelines or procedures to all employees? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Are all employee terminations reviewed with human resources and inside/outside counsel? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Do the Applicant and all Subsidiaries use outside counsel for employment advice? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Do the Applicant and all Subsidiaries have a full-time human resource manager? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Have all management staff and officers of the Applicant or any Subsidiary attended training and education programs on sexual harassment and discrimination within the last 18 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PART IV – FIDUCIARY LIABILITY (To be completed only if Applicant is Seeking Fiduciary Liability Coverage)		
Single Employer Plans Only; multi-employer and/or union ERISA plans are not covered by this application)		
1. Please indicate the type of plans for which insurance is requested:		

Type	Name of Plan(s)	Assets	Trustee	Plan Administrator
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		

Total asset value for all plans: \$

Types: DB = Defined Benefit DC = Defined Contribution P = Pension W = Welfare E = ESOP O = Other

2. Total number of participants (including retirees) enrolled in all plans:

3. Do any plans not conform to the standards of eligibility, participation, vesting and other provisions of the Employee Retirement Income Security Act of 1974 (ERISA) as amended or similar laws? Yes No

4. Are any of the plans under funded by more than 20%, or is the Applicant delinquent in contributing to any plans? Yes No

5. Have any plans been terminated, suspended, merged, dissolved, or converted to a cash balance plan within the last 24 months? Yes No

6. Does the Applicant or any Subsidiary plan on terminating, suspending, merging or dissolving any plan within the next 12 months? Yes No

7. Are more than 10% of the assets of any plan (other than an ESOP) invested in any securities of or loan to the Applicant, or in any real estate? Yes No

If yes to any of the above, please provide details:

8. Are plan participants educated annually regarding investment alternatives? Yes No

9. Are the plans reviewed annually to assure there are no violations of any plan trust agreements, prohibited transactions or party-in-interest rules? Yes No

PART V – To be completed by the Applicant

Place a check next to the boxes below where Applicant has current coverage in place either with CNA or with any other carrier:

Place a check next to the boxes below where Applicant has no current coverage in place:

Directors and Officers Liability

Directors and Officers Liability

Employment Practices Liability

Employment Practices Liability

Entity Liability

Entity Liability

Fiduciary Liability

Fiduciary Liability

Professional Liability

Professional Liability

*The Warranty set forth below is inapplicable to those coverages checked above and should not be completed if the Applicant is requesting continuity.

Current coverage has been in place since: _____

The Warranty set forth below applies only to those coverages checked above.

Warranty: None of the individuals to be insured under any Coverage Part (the "Insured Persons") is responsible for or has knowledge of any wrongful act or fact, circumstance or situation which (s)he has reason to suppose might result in a future claim, except as follows:


A. **Exceptions to the Warranty:** Yes (please attach details)

B. **No Exceptions:** Please check here if there are no exceptions to the Warranty

1. It is agreed by all concerned that if any of the Insured Persons is responsible for or has knowledge of any wrongful act, fact, circumstance, or situation which s(he) has reason to suppose might result in a future claim, whether or not described above, any claim subsequently emanating there from shall be excluded from coverage under the proposed insurance as to (i) such of the insured persons and (ii) the applicant, subsidiaries and the plan if such insured persons are executive officers. The responsibility or knowledge of any individual shall not be imputed to any other individual for the purposes of determining the availability of coverage.

2. It is declared that this application and any materials submitted or required (which shall be maintained on file by the Insurer and be deemed attached as if physically attached to the proposed Policy) are true and are the basis of the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

3.	The undersigned declares that to the best of his/her knowledge the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information from all of the Insured Persons to facilitate the proper and accurate completion of this application for the proposed Policy. Signing of this application does not bind the undersigned to purchase the insurance, but it is agreed that this application shall be the basis of the contract should a Policy be issued, and this application will be attached to and become part of such Policy. The undersigned agrees that if after the date of this application and prior to the effective date of any Policy based on this application, any occurrence, event or other circumstance should render any of the information contained in this application inaccurate or incomplete, then the undersigned shall notify the Insurer of such occurrence, event or circumstance and shall provide the Insurer with information that would complete, update or correct such information. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Insurer.
4.	The information requested in this application is for underwriting purposes only and does not constitute notice to the Insurer under any Policy of a claim or potential claim. All such notices must be submitted to the Insurer pursuant to the terms of the Policy, if and when issued.
	The undersigned acknowledges that he or she is aware that defense costs reduce and may exhaust the applicable Limits of Liability. The Insurer is not liable for any loss (which includes defense costs) in excess of the applicable Limits of Liability.
	Warning – Arkansas, Colorado, Florida, Hawaii, Kentucky, Louisiana, New Jersey, New York, Maine, Ohio, Oklahoma, Pennsylvania and Virginia Residents Only 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 (for New York residents only): and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation). Warning – for Colorado Residents Only Any insurance company or agent or an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. Warning – for Hawaii Residents Only For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
	This applicant must be signed by the Chairman of the Board, Chief Executive Officer or by the President.
	Name of Chairperson, Chief Executive Officer, President, Chief Financial Officer or General Counsel (Please Type or Print): :
	Signed:
	Title:
	Corporation:
	Date:



VICTOR O.
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Underwriting Managers and Program Administrator

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