



SUPPLEMENT FOR EMPLOYEE BENEFITS LIABILITY COVERAGE

All questions MUST be completed in full. If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____
2. Total number of employees under the Applicant's Employee Benefits programs. _____
3. Does the Applicant have a full-time human resource manager or department? [] Yes [] No
4. For elective Employee Benefit programs, does the Applicant obtain and retain a signed acceptance or rejection form from every eligible employee? [] Yes [] No
5. Is a written guide of the Applicant's Employee Benefits programs provided to every employee? [] Yes [] No
 If Yes, does the Applicant obtain and retain written acknowledgement of its receipt from every employee? [] Yes [] No
6. Has (have) any Employee Benefits Liability judgment(s), settlement(s), payment(s), claim(s), suit(s) or demand(s) been made against any person(s) or entity(ies) proposed for this insurance? [] Yes [] No
 If Yes, provide details. _____
7. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any facts, circumstances or situations which might afford grounds for any Employee Benefits Liability claim? [] Yes [] No
 If Yes, provide details. _____
8. Has any insurer declined, cancelled or nonrenewed any Employee Benefits Liability policy for any person(s) or entity(ies) proposed for this insurance? [] Yes [] No
 If Yes, provide details. _____
9. Does the Applicant currently carry Employee Benefits Liability Insurance? [] Yes [] No
 If Yes, provide the following:

Name of Insurer	Limits	Policy Period	Deductible/Retention	Premium	Retro/Prior Acts Date
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NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

For the purpose of this supplement, the undersigned authorized agent of the person(s) and entity(ies) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this supplement and in any attachments, are true and complete. This supplement, information submitted with this supplement and all previous supplements and material changes thereto of which underwriting manager, Company and/or affiliates thereof receives notice is on file with underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this supplement and all such attachments in issuing the policy.

Signing this supplement does not bind the Company to provide or the Applicant to purchase the insurance. It is understood that information submitted herein becomes a part of the application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent (within 60 days of the proposed effective date).

 Name of Applicant

 Title

 Signature of Applicant

 Date