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APPLICATION FOR SALTING POLICY

Application for (check one) ☐ **EPLI and Salting Coverage** ☐ **Salting Coverage Only**

PART I - General Information

1. Full legal name of proposed **Named Insured**: _____

2. Principal place of business (street address, city, state and zip)(**Location (1)**): _____

   _____

3. (a) **Years in business** under current and all former corporate names: _____

   (b) If Named Insured is subsidiary, name of **parent company***:* _____

4. Please list all other insured locations, including addresses, **corporate names**, years in business and relationship to Named Insured (e.g.; ***subsidiaries, affiliates***) on a separate sheet of paper and attach it to this application.

5. Estimated **Annual Sales** for Policy Period: _____ **Annual Payroll**: $_____

6. Name of **present EPLI insurer**, **limits** and **retroactive date**: _____

7. Describe **business activities** and **SIC codes** applicable to each insured location and show number of all employees at each such location. ***(Note: Include all temporary and seasonal employees as well as officers, owners and partners who are active in the business (including all affiliates.)***

Location No.	Primary Business Activities	SIC Code	# Full-time Reg.	# Full-time Seas/Temp	# Part-time Reg.	# Part-time Seas/Temp
(1)						
(2)						
(3)						
(4)						

8. Indicate **employment turnover at each insured location during the last three years** (***please, show separate figures for voluntary and involuntary terminations):***

Location Number	# Full-time Employees **hired**	# Full-time Employees **terminated** (vol./invol.)	# Part-time Employees **hired**	# Part-time Employees **terminated** (vol./invol.)
(1)		/		/
(2)		/		/
(3)		/		/
(4)		/		/

9. Indicate estimated **employment turnover for each location for the next twelve (12) months** (***please, show separate figures for voluntary and involuntary terminations):***

Location Number	# Full-time Employees **hired**	# Full-time Employees **terminated** (vol./invol.)	# Part-time Employees **hired**	# Part-time Employees **terminated** (vol./invol.)
(1)		/		/
(2)		/		/
(3)		/		/
(4)		/		/

10. Indicate **current number of employees for each location by length of employment**:

Location No.	**Less than 2 years**	**2-5 years**	**6-10 years**	**11-20 years**	Over 20 years
(1)					
(2)					
(3)					
(4)					

11. Indicate current number of persons serving as **partners, directors and officers by salary range:**

# Partners	# Director/Officers	**#** Outside Directors	#Officers	Salary Range
				$50,000 or less
				$50,001-$100,000
				$100,001-$200,000
				Over $200,000

12. Indicate current number of **all other employees** for all insured locations **by salary range**, as follows:

Managers/ Supervisors	Sales & Marketing Personnel	Full-time Non-managerial Employees	Part-time Employees	Salary Range
				$50,000 or less
				$50,001-$100,000
				$100,001-$200,000
				Over $200,000

13. Name(s) of **persons responsible for personnel, human resources, labor relations and industrial safety** (indicate precisely all the duties, authority and experience/credentials of each such person):

Names	Duties	Authority	Experience/Credentials

14. Indicate total number of **charges filed with the NLRB, EEOC or state agency**, against each location/state, whether by current employees, terminated employees or employees not hired, over the last **seven** years:

Location No.	Year _____	Year _____	Year_____	Year _____	Year _____	Year _____	Year _____
(1)							
(2)							
(3)							
(4)							

15. Of the total number of EEOC/state agency charges filed, indicate the **primary allegations** as follows:

Location No.	(1)Racial Discrimination	(2) Age Discrimination	(3) Religious Discrimination	(4) Other Ethnic Discrimination	(5) Fair Labor Standards Act Violation	(6) Gender Discrimination /Sexual Harass.	(7) Violation of Am. with Disab. Act	(8) Unfair Labor Practice	(9) All Others
(1)									
(2)									
(3)									
(4)									

16. With respect to **litigated cases** (including wrongful termination suits under state law other than anti-discrimination law) **and NLRB/EEOC/state agency charges over the last *seven* years for which any settlement was or may be paid**, please provide the following information, which **must be currently valued**:

Date of Occurrence	Claimant	Allegation (if applicable, use # from Ques. 15)	Damages Paid	Damages Reserved	Legal Expense Paid	Legal Expense Reserved

17. Describe your pre-employment screening procedures, including testing: _____

18. Describe all **procedures for disciplining and terminating employees**, including grievance or review procedures, and procedures for investigating employee complaints about working conditions, sexual harassment and pay disparities (if contained in manuals, then so state): _____

19. Describe **methodology** used for **promoting** employees and/or **increasing salaries and wages** (if contained in manuals, then so state): _____

20. Provide names and positions of persons with whom any insured has **written employment agreement(s)**: _____

21. Does any proposed insured plan to close any office or plant during the next twelve months?

☐ Yes ☐ No. If yes, please explain: _____

22. Does management of any insured plan to form any new businesses, open any new locations or acquire any new companies during the next twelve months? ☐Yes ☐No.

If yes, please explain: _____

23. Is management of any insured aware of any facts, incidents or circumstances that may result in claims being made against any insured in the next twelve months? ☐Yes ☐No.

If yes, please explain: _____

24. (a) Is management of any insured, at any location, aware of any current salting effort? ☐Yes ☐ No If yes, please explain: _____

_____

_____

(b) Is the Named Insured a member of the Associated Builders & Contractors? ☐Yes ☐ No

25. Are all the proper notification posters required by law displayed prominently? ☐Yes ☐No.

If not, please explain: _____

26. Have job descriptions been drafted for most regular full-time positions? ☐Yes ☐No.

If not, please explain: _____

27. How many disabled persons are employed (for all locations)? _____ How does management make accommodations for their disabilities? _____

28. How long do you keep employment applications on file? _____

29. The following additional documents and information must accompany this application and form a part of the application (check those that are submitted with this submission---*those marked with an * are mandatory, all others must be included only if applicable or if they exist):*

☐ Employment Application Forms *
☐ Last Audited Financial Statement ***(if available)***
☐ Written Employment Contracts (***if any)***
☐ Collective bargaining agreements (***if applicable)***
☐ Affirmative Action plans (***if applicable)***
☐ Current 23-month income statement and balance sheet*
☐ EEO-1 filings for the last 7 years (***if applicable)***
☐ Supervisory & employment manuals (***if any)***
☐ Employment evaluation forms (***if any)***
☐ Other (specify Question # reference): _____

☐ ***If this is a non-profit entity, provide names and present employment of all board members***

NOTICE: The Policy for which application is made is a Claims Made and Reported Policy. Except as otherwise stated in the Policy, this insurance is limited to liability for only those **Claims** that are first made against the insured during the **Policy Period** or the Extended Reporting Period, if exercised, and reported to the Company during the **Policy Period** or the Extended Reporting Period, if exercised. Please read the Policy carefully.

WARRANTY*:* The signatory below warrants that he/she has been authorized on behalf of the applicant(s) to make the representations contained herein, and that the information contained herein is substantially true to the best of his or her knowledge and shall become the basis of the policy of insurance for which application is hereby made and is deemed incorporated therein if Markel Midwest, Inc. evidences its acceptance of this application by issuance of a policy or by any other evidence of insurance.

_____ _____

Name of Applicant Title (Officer, partner, etc.)

_____ _____

Signature of Applicant Date

N.B.: Signing this form does not bind the applicant or Markel Midwest, Inc. to complete the contract of insurance. This application must be signed and dated in order to be considered for quotation purposes. The soliciting insurance broker must be licensed in your state as a surplus lines broker.

FRAUD PREVENTION – WARNING

ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, SUBMITS AN APPLICATION OR FILES A CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY WHICH CONTAINS ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION OR STATEMENT IS GUILTY OF THE FELONY CRIME OF INSURANCE FRAUD AND MAY BE SUBJECT TO CIVIL FINES AND CONFINEMENT IN PRISON.

WARNING – Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of 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 – Florida Residents: 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.

WARNING – New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

WARNING – New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

WARNING—New York Residents: 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 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 – Pennsylvania: 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 subjects such person to criminal and civil penalties.

☐ **Deerfield Insurance Company**
☐ **Evanston Insurance Company**
☐ **Essex Insurance Company**
☐ **Markel American Insurance Company**
☐ **Markel Insurance Company**
☐ **Associated International Insurance Company**

DISCLOSURE NOTICE OF TERRORISM
INSURANCE COVERAGE AND ELECTION FORM

RE:
Risk ID. No.:

You are hereby notified that under the Terrorism Risk Insurance Act as amended, that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, *as defined in Section 102(1) of the Act*: The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

You should know that where coverage is provided by this policy for losses caused by certified acts of terrorism, such losses may be partially reimbursed by the United States Government under a formula established by federal law. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under this formula, the United States Government generally reimburses 85% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The premium charged for this coverage is provided below and does not include any charges for the portion of loss covered by the federal government under the Act.

You should also know that the Terrorism Risk Insurance Act as amended, contains a $100 billion cap that limits United States Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism when the amount of such losses in any one calendar year exceeds $100 billion. If the aggregate insured losses for all insurers exceed $100 billion, your coverage may be reduced.

SELECTION OR REJECTION OF TERRORISM INSURANCE COVERAGE

PLEASE ENTER "X" IN ONE OF THE BOXES BELOW AND SIGN AND DATE WHERE INDICATED BELOW.

Alaska, Florida, Georgia and Oklahoma Applicants: Please be advised that in the event a policy is purchased, the policy premium will include a 1% surcharge for Terrorism Coverage unless you elect to decline Terrorism Coverage. You need to enter an "X" below if you wish to decline Terrorism Coverage.

	I hereby elect to purchase the Terrorism Coverage required to be offered under the Act. I understand that my policy premium will include a 3% surcharge for this coverage.
	I decline to purchase the Terrorism Coverage required to be offered under the Act. I understand that my policy will be endorsed to exclude the Terrorism Coverage required to be offered under the Act.

Name of Applicant _____ Title (Officer, partner, etc.) _____

Signature of Applicant _____ Date _____

SIGNING this Disclosure Notice does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance.