



**EMPLOYMENT PRACTICES SUPPLEMENT**

Name of Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

1) Provide the following number of employees:

- \_\_\_\_\_ Total Employees
- \_\_\_\_\_ Part-Time (including leased employees)
- \_\_\_\_\_ Full-Time
- \_\_\_\_\_ Employees working in Non-U.S. locations
- \_\_\_\_\_ Union Employees

2) Provide the number of employees by the following salary ranges:

<u>Salary Ranges</u>	<u>Number of Employees</u>
\$ 0 - 25,000	_____
25,001 - 50,000	_____
50,001 - 100,000	_____
over 100,000	_____

3) List the five states with the largest number of employees:

<u>State</u>	<u>Number of Employees</u>
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____



- 9) Please provide the following details on any Claim(s) paid or reserved (anticipated to cost) in excess of \$10,000 (including defense costs):
- a. Date of loss
  - b. Description of the loss, including current status
  - c. Amount paid or reserved (including defense costs)
  - d. Does the Claim name any Directors, Officers, or Employees of the Company?

The Insurer is hereby authorized to make any investigation or inquiry in connection with this supplement as it deems necessary.

The Undersigned hereby authorizes the release of Claim information from any prior insurer to the Insurer.

- 10) Is any person proposed for this insurance aware of any fact, circumstance or situation which may result in a claim against the Company or any of its Directors, Trustees, Officers, or Employees based upon or attributable to Discrimination, Wrongful Termination, or Sexual Harassment?

None

None except (give details) \_\_\_\_\_

**IT IS AGREED BY ALL CONCERNED THAT IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM SUBSEQUENTLY EMANATING THEREFROM SHALL BE EXCLUDED FROM THE COVERAGE FOR WHICH INSURANCE IS SOUGHT.**

Although the signing of this supplement does not bind the undersigned on behalf of the Directors, Officers, and Employees to effect Insurance, the undersigned, on behalf of the Directors, Officers, and Employees, agrees that this supplement and the information furnished pursuant hereto shall be the basis of the contract should a policy be issued and this supplement will be attached to and become part of the policy. The Insurers are hereby authorized to make any investigation and inquiry in connection with this supplement as they may deem necessary.

Signed: \_\_\_\_\_  
 Must be Signed by Chairman of the Board or President

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

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