



DRISCOLL

EPLI Quick Quote

Send Completed Quote Form to:
 (562) 252-8711 or quotes@driscollinsured.com or
 complete at driscollinsured.com/epli

EMPLOYMENT PRACTICES LIABILITY INSURANCE

Company name: _____ Date Organized: _____
 (If there is more than one location, attach a separate list including address, corporate name and number of employees at each location)

Address: _____ City: _____ State: _____

Description of operations: _____

EMPLOYEES

Current number of employees for all locations/subsidiaries: _____ FT _____ PT

Has the company had any layoffs (excluding seasonal layoffs), staff reductions, downsizing, or office or plant closings in the past twelve months? (If yes, complete our Reduction in Force Supplement) yes no

Does the company anticipate any layoffs (excluding seasonal layoffs), staff reductions, downsizing, or office or plant closings in the next twelve months? (If yes, please complete our Reduction in Force Supplement) yes no

PAST HISTORY

Within the past three years, has the company had any lawsuits, threatened claim, or charges filed with the EEOC or state/local administrative agency involving a Wrongful Employment Act, or Third-Party Wrongful Act? (If yes, please complete our Claim Supplement for each claim.) yes no

(New applicants only) Does any director, officer, owner, member or partner of the Company have knowledge of any fact, circumstance, or situation that may result in a Claim, such as would fall under proposed insurance? (If yes, please complete our Claim Supplement for each claim.) yes no

LOSS PREVENTION

Does the Company currently have AND regularly distribute the following written policies?

- | | | | |
|------------------------------|--|---------------------|--|
| Employment at-will statement | <input type="checkbox"/> yes <input type="checkbox"/> no | Grievance Procedure | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Anti-Discrimination | <input type="checkbox"/> yes <input type="checkbox"/> no | | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Anti-Sexual Harassment | <input type="checkbox"/> yes <input type="checkbox"/> no | | <input type="checkbox"/> yes <input type="checkbox"/> no |

PRIOR COVERAGE

Do you currently carry employment practices liability insurance? (If yes, please provide details below) yes no

Policy Expiration _____ Insurer _____ Limit _____ Deductible _____ 1st year coverage started _____

DESIRED COVERAGE

Desired Limit of Liability _____ Desired Deductible _____

APPLICANT SIGNATURE

By _____ Print Name _____
 (Signature of President or Officer)

Title _____ Date _____ Phone _____

Email _____ Web site _____