Employee Benefits Liability Supplemental Application

AmTrust E&S Insurance Services
An AmTrust Financial Company

*To be able to save this form after the fields are filled in, you will need to have Adobe Reader 9 or later. If you do not have version 9 or later, please download the free tool at: http://get.adobe.com/reader/.

Instructions: All questions must be answered. This application must be signed and dated by an owner, officer or partner. Please read carefully the statements at the end of this application.

Section I – Applicant Information

Name of Applicant: _____ Today's Date: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Website Address: _____

Section II – Employee Benefits Information

1. Limits of insurance requested:
Each Employee: $ _____ Aggregate: $ _____ Retroactive Date: _____

2. Number of employees covered by the Employee Benefits Plan: _____

3. Is the Employee Benefits Program offered to non-employees? ☐ Yes ☐ No

4. Are any benefits offered to part-time employees? ☐ Yes ☐ No

5. Do you administer any benefit plans on behalf of others? ☐ Yes ☐ No
If YES, provide details:
_____

6. Have you rejected the Workers' Compensation Acts in any state? ☐ Yes ☐ No

Employee Benefits Provided:

7. Type(s) of Benefit Programs currently administered (please check all applicable boxes):

☐ Group Life	☐ Group Profit-Sharing Plan	☐ Social Security Benefits
☐ Group Accident	☐ Pension Plan	☐ Workers' Compensation
☐ Group Health	☐ Stock Subscription Plan	☐ Disability Benefits Insurance
☐ Group LTD	☐ Unemployment Insurance	☐ Other: _____

Benefit Plan Administration:

8. Does the Applicant have a full-time human resource manager or department? ☐ Yes ☐ No

9. Are personnel who counsel employees on their benefits familiar with the details of the programs? ☐ Yes ☐ No

10. Does each employee receive a benefit brochure or written explanation of the Employee Benefits Program? ☐ Yes ☐ No
If YES, does the Applicant obtain and retain written acknowledgement of its receipt from every employee? ☐ Yes ☐ No

11. For elective Employee Benefit programs, does the Applicant obtain and retain a signed acceptance or rejection form from every eligible employee? ☐ Yes ☐ No

12. Are Group Life, Group Accident, Group Health, Pension plans, Profit-Sharing plans or Stock Subscription plans available to non-employees? ☐ Yes ☐ No

13. Are all programs in compliance with COBRA requirements? ☐ Yes ☐ No

14. Has coverage ever been declined or cancelled? ☐ Yes ☐ No
If YES, provide details:
_____

15. Has the Applicant ever sustained any error or omission loss or does the Applicant have any pending? ☐ Yes ☐ No
If YES, provide details:
_____

16. Does the Applicant have knowledge of an occurrence, which might result in a claim? ☐ Yes ☐ No
If YES, provide details:
_____

Fraud Warning

Any person who, with intent to defraud or knowing that (s)he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

ALABAMA, ARKANSAS, LOUISIANA, MARYLAND, NEW JERSEY, NEW MEXICO and VIRGINIA: 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. In Alabama, Arkansas, Louisiana and Maryland, that person may be subject to fines, imprisonment or both. In New Mexico, that person may be subject to civil fines and criminal penalties. In Virginia, penalties may include imprisonment, fines & denial of insurance benefits.

COLORADO: 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.

DISTRICT OF COLUMBIA, KENTUCKY and 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 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. In District of Columbia, penalties include imprisonment and/or fines. In addition, the Insurer may deny insurance benefits if the Applicant provides false information materially related to a claim. In Pennsylvania, the person may also be subject to criminal and civil penalties.

FLORIDA and OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive the Insurer, files a statement of claim or an Application containing any false, incomplete or misleading information is guilty of a felony. In Florida it is a felony to the third degree.

KANSAS: An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an Insurer, purported Insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for personal or commercial insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto is considered a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

NEW YORK: 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 five thousand dollars and the stated value of the claim for each such violation

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against the Insurer, submits an Application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OREGON: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and/or denial of insurance benefits.

Representation Statement

I hereby apply for a policy of insurance as set forth in the application and I declare that all information contained in this application is correct and complete to the best of my knowledge and belief. I understand that any policy which may be issued by the company will be issued on the basis of and reliance upon my statements in this application. I agree that such policy shall be null and void if such information is false, or misleading, or would materially affect acceptance of the risk by the company.

The signing of this application does not bind the undersigned to purchase the insurance and accepting this application does not bind the Insurer to complete the insurance or to issue any particular policy. If a policy is issued, it is understood and agreed that the Insurer relied upon this application in issuing each such policy and any endorsements thereto. The undersigned further agrees that if the statements in this application change before the effective date of any proposed policy, which would render this application inaccurate or incomplete, notice of such change, will be reported in writing to the Insurer immediately.

The Application must be signed and dated by a Principal, Partner, Managing Member or Senior Officer of the Applicant. Electronically reproduced signatures will be treated as original.

Applicant:

Print Name: _____ Signature: _____

Title: _____ Date: _____

I hereby declare that all the information contained in this application is correct and complete to the best of my knowledge and belief, that the application was complete and personally signed by the applicant and that a completed copy hereto has been given to the applicant.

Name of Producing Agency: _____

Signature of Producing Agent: _____ Date: _____

SIGNING THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY

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