

**EMPLOYEE BENEFITS LIABILITY
SUPPLEMENTAL APPLICATION**

Applicant Name: _____

Mailing Address: _____

The following Employee Benefit Programs are covered by the insurance without specific listing by the Applicant:

- | | |
|-------------------------------|------------------------------|
| Group Life Insurance | Pension Plans |
| Unemployment Insurance | Group Health Insurance |
| Social Security | Employee Stock Reimbursement |
| Profit Sharing Plans | Workers' Compensation |
| Disability Benefits Insurance | |

1. List below any other Benefit Programs to be considered for Coverage:
2. How Frequent are open enrollment periods for Group Health Insurance?
3. Is a physical exam required prior to enrollment in a Group Health/Life Insurance Program?

For new hires?	Yes _____	No _____
During open enrollment?	Yes _____	No _____
Any other time?	Yes _____	No _____

4. If the requested coverage had been in force during the past 5 years, were there any incidents that could have resulted in claims under such coverage?
Yes _____ No _____

If Yes, describe each (use separate sheet if necessary):

5. Does the Applicant have any knowledge of occurrences, which might in the future result in a claim under this insurance?

Yes _____ No _____

6. Does the Applicant maintain a unit to administer Employee Benefits Programs, answer

Yes _____ No _____

If Yes, please indicate number of Employees in unit: _____

7. On Programs permitting employees the option to enroll in a Program, does the Applicant require a signed acceptance or rejection from each employee?

Yes _____ No _____

If No, describe:

8. Does the Applicant have a loss or accident control program?

Yes _____ No _____

If Yes, attach a description and copy of the program.

ATTACH:

- Copies of any pamphlets, brochures or benefit summaries distributed by the Applicant describing any of the Employee Benefits Programs.
- Full details regarding the administration of the Applicant's Employee Pension Fund, if it is funded from a financial institution.
- Full details regarding the administration of the Applicant's Employee Profit Sharing Plan, if it involves funding from a financial institution.

THE APPLICANT WARRANTS THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE DATE ON WHICH COVERAGE IS BOUND, THE APPLICANT WILL IMMEDIATELY NOTIFY THE INSURANCE COMPANY OF SUCH CHANGES. THE SIGNING OF THE APPLICATION DOES NOT BIND THE INSURANCE COMPANY TO PROVIDE THE REQUESTED COVERAGE, BUT IT IS AGREED THAT IF A POLICY IS ISSUED, THIS APPLICATION SHALL BE THE BASIS FOR THE POLICY, AND IT WILL BE ATTACHED TO AND MADE PART OF THE POLICY.

APPLICANT'S SIGNATURE

DATE