

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

1. List below any other Benefit Programs to be considered for Coverage:

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2. How Frequent are open enrollment periods for Group Health Insurance?

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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):

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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

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

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**