EMPLOYEE BENEFITS LIABILITY
SUPPLEMENTAL APPLICATION

Applicant Name: ____

Mailing Address: ____

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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.

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APPLICANT'S SIGNATURE **DATE**