

BB&T INSURANCE SERVICES

110 Dixie Street
Carrollton, Georgia 30117
Office 1-800-356-9804 Fax 1-888-751-2997

TO: _____
COMPANY: _____
FAX #: _____
DATE: _____
SUBJECT: DATIA Professional Liability Application
Specified Medical Professional Liability Application
Commercial Lines Supplemental Application
Employment Practices Liability Application (Including
Third Party)

This is a **23** page document (including cover sheet)
The DATIA Professional Liability insurance program is endorsed by DATIA, and was specifically designed for drug and alcohol testing facilities. We have the following products available:

LINE OF COVERAGE	CARRIER	ACCEPT/REJECT QUOTE
DATIA Professional Liability (Testing Services, Background Checks, & MVR's)	Markel Insurance Co.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Specified Medical Professional Liability (Phlebotomy, First Aid Training, CPR Training, Flu Shots, Inoculations, & Physical Examinations)	Markel Insurance Co.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Commercial Lines (YOU MUST MAINTAIN THE DATIA PROFESSIONAL LIABILITY TO QUALIFY FOR THESE COVERAGES)	Zurich	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Practices Liability (Including 3 rd Party Sexual Harassment)	United States Liability Company	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you would like a quotation, please accept/reject above, complete the attached applications for Lines of Coverage(s) desired to be quoted and return to our office. Please note that all members may not qualify for all products.

Should you have any questions, please contact our office at 1-800-356-9804. We are committed to providing you with the very best combination of service, protection, & price. Thank you for the confidence you have placed in BB&T Insurance Services, Inc.

Please quote the above "Lines of Coverage" as per the enclosed applications.

X

Applicant Signature _____ Date _____

For your convenience, we have included a fax cover sheet to our office. Thank you!

NOTE:

THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPY OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AND RETURN THE ORIGINAL MESSAGE TO US. THANK YOU.

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CONFIDENTIAL

TO: BB&T Insurance Services, Inc.
110 Dixie Street
Carrollton, Georgia 30117

FAX #: 1-888-751-2997

DATE:

FROM:

SUBJECT: DATIA Professional Liability
Specified Medical Professional Liability
Commercial Lines Coverages
Employment Practices Liability (Including Third Party)

This is a page document (including cover sheet)

Please quote the **DATIA Professional Liability** as per the attached application. I understand that I will be receiving this proposal from Paula D. Layton.

Please quote the **Specified Medical Professional Liability** as per the attached application. I understand that this application will be submitted to the carrier to quote and I will receive this proposal from Paula D. Layton when received from the carrier.

Please quote **Commercial Lines Coverages** as per the attached information. I understand that I will be receiving this proposal from Lynn Debnam.
(YOU MUST MAINTAIN THE DATIA PROFESSIONAL LIABILITY TO QUALIFY FOR THESE COVERAGES)
Toll Free: (877) 643-6227 toll-free #1 then #38 or Direct Line: (919) 716-9956
E-Mail: ldebnam@BBandT.com

Please quote **Employment Practices Liability** as per the attached application. I understand that this application will be submitted to the carrier to quote and I will receive this proposal from Paula D. Layton when received from the carrier.

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BB&T INSURANCE SERVICES

Reg V. Davis, Account Executive
Paula D. Layton, Account Manager

110 Dixie Street
Carrollton, Georgia 30117

1-800-356-9804

Phone 770-214-1991 Fax 1-888-751-2997

E-Mail Address: PDLayton@bbandt.com

IS THE COST OF PROFESSIONAL LIABILITY INSURANCE "TESTING" YOUR PATIENCE?

As a member of the **Drug and Alcohol Testing Industry Association (DATIA)**, you are eligible for a competitive insurance quote. The DATIA Professional Liability insurance program is endorsed by your Association, **DATIA**, and was specifically designed for drug and alcohol testing facilities.

When it comes to protecting your business investment, you need an insurance program that has that same objective.

The **DATIA Professional Liability** policy provides legal liability resulting from negligence, errors and omissions and other aspects of rendering or failure to render professional services relating to Drug and Alcohol Testing. It does not cover fraudulent, dishonest or criminal acts. This policy is not a medical malpractice policy and does not offer coverage for bodily injury arising out of the rendering or failure to render professional medical services.

Limits of Liability: \$1,000,000 each claim, \$1,000,000 Aggregate

We can write up to \$3,000,000 Aggregate

Deductible: \$2,500 per Claim, with optional \$1,000 Deductible available

"A" Rated, Admitted Insurance Carrier

Premium Based on Number of Test Performed

Minimum Premium: \$1,500

Call us today for your application or visit the DATIA website



MARKEL INSURANCE COMPANY

DRUG & ALCOHOL TESTING INDUSTRY ASSOCIATION (DATIA) ERRORS AND OMISSIONS LIABILITY APPLICATION

APPLICANTS INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Signing of this application does not bind the Company to offer nor the Applicant to accept insurance.
4. It is agreed that this application will be part of the insurance policy, if issued.
This is an application form for a claims made policy.

I. GENERAL INFORMATION:

- A. Legal Name of Business: _____
(Example: ABC Drug Testing Inc dba: Drug Testing)
- B. Mailing Address: _____

Location Address: _____

Email Address: _____
- C. Phone Number: _____ Fax Number: _____
Cell Phone: _____
Federal ID Number : _____
Social Security Number IF company is "Sole Proprietor": _____
- D. Executive Officer in Daily Management: _____
(Name) (Title)
- E. _____ Sole Proprietorship _____ Corporation _____ Partnership _____ LLC
- F. Year Business Began? _____ (If under one year, indicate month also)
- G. Member of DATIA? _____ Yes _____ No Member # _____
- H. Are you accredited? _____ Yes _____ No

II. LOSS HISTORY:

- A. Furnish loss history (3 years) for all claims alleging errors in the drug testing process)
If no prior claims, write NONE.
- | Date Claim First Made | Paid Damages/Expenses Including Attorney Fees | Outstanding Damages/Expenses Including Attorney Fees | Total Damages |
|-----------------------|---|--|---------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please provide a full description of each claim on a separate sheet.

- B. Are you aware of any facts, incidents or circumstances which may result in claims being made against you under the proposed insurance policy?
(If yes, please provide details on separate sheet) ___ Yes ___ No
- C. Has the proposed coverage ever been purchased before, whether specifically or as part of another insurance contract? ___ Yes ___ No
- D. Has any insurer ever canceled or non-renewed this type of coverage?
(If yes, please provide details on separate sheet) ___ Yes ___ No

E. Have you or any of your employees ever been the subject of disciplinary or investigative proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ___Yes ___No
 (If yes, please provide details on separate sheet)

F. Provide the following information for any similar insurance, if any, carried during the last three years. If no prior coverage, write NONE.

Company	Policy Limit	Deductible	Annual Premium	Policy Term
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

III. **EMPLOYEES:**

1. Number of employees: Full Time: _____ Part Time: _____

IV. **SCOPE OF BUSINESS SERVICES:**

Please answer the following and also attach your current service description brochures.

Do you perform any or all of the following services? (If you provide some, but not all of the services, please explain on an attached sheet.)	Please Check If Yes	% of Clients' Total Tests
(1) As a Third Party Administrator/Facilitator: Obtaining, contracting with and managing collection sites, breath alcohol technicians, laboratories, medical review officers (MRO).	_____	_____
(2) Do you or your employees actually perform any of the above listed services. If so, which (✓): <u>Collection</u> <input type="checkbox"/> /lab tests <input type="checkbox"/> / medical review <input type="checkbox"/>	_____	_____
(3) Urinalysis or alcohol blind specimen quality assurance	_____	_____
(4) Preparation of or consulting on company policies on substance abuse.	_____	_____
(5) Random testing administration.	_____	_____
(6) 24-hour post accident and reasonable cause testing administration.	_____	_____
(7) Other _____	_____	_____

V. TEST ADMINISTRATION:

(1) Please provide estimated testing count for the coming year for the following classes:

	<u>No. of Tests</u>
A Drug Test (Urine)	
(1) Collection only (by you/employee)	_____
(2) Lab Test only (by you/employee)	_____
(3) Collection, Lab Test and/or Medical Review (by you/employee)	_____
(4) Facilitation Only (TPA)	_____
B Alcohol Test (Breath or Blood)	
(1) Performed by you/employee	_____
(2) Performed by Independent Contractor	_____
C. DRUG OR ALCOHOL TEST	
Hair	_____
Chemical Profiling	_____
Immediate Response Urine Test/Rapid Drug Test	_____
Adulteration Testing	_____
Surface Detection of Illegal Drugs	_____
Sweat	_____
Oral Fluid	_____
Fingernail or Toenail	_____
D. DNA Testing	_____
E. HIV Testing	_____
F. TB Testing	_____
TOTAL TESTS	_____
Background Checks (Outside Company used to provide service)	_____
MVR's (Outside Company used to provide service)	_____
TRAINING SESSIONS FOR CLIENTS Number per Year (as it relates to drug testing only)	_____

Further explanation:

VI. MEDICAL REVIEW OFFICER (for each associated MRO):

Name _____ Address: _____
 Employee _____ Independent _____ Accrediting Organization _____

VII. LABORATORY:

Please list all laboratories that provide testing services to any of your employer clients:

	SAMHSA Certified	
	Yes	No
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

X

_____ Date _____ Applicant's Authorized Signature (Principal, Partner or Officer) _____ Title _____

MAIL OR FAX TO:
BB&T INSURANCE SERVICES, INC.
 110 Dixie Street
 Carrollton, Georgia 30117
 Toll Free 1-800-356-9804
 Phone: (770) 214-1991
 Fax: 1-888-751-2997



Specified Medical Professional Liability Insurance

The Problem

Recent medical advancements have bred a wide spectrum of new healthcare providers, all of whom need professional liability insurance. Finding quality coverage that can be relied upon to respond to potential E&O exposures can be challenging.

The Risk

Expensive and professionally damaging claims or lawsuits filed against allied healthcare providers and the facilities in which they work.

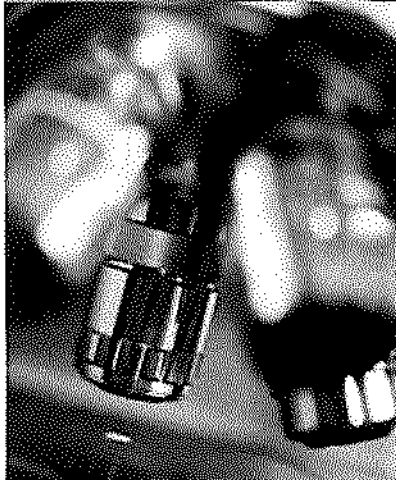
The Solution

Specified Medical Professional Liability Insurance for allied healthcare professionals and entities, offered through Markel.*

Steadily rising costs have brought big changes to the healthcare industry. Increasingly, medical services are being offered by providers outside of the hospital setting. Those providers or entities where services are rendered would benefit from the professional and general liability offered through Markel.

*The Markel Advantage**

- Flexible E&O insurance coverage for a wide variety of medical organizations and professionals. Target classes include the following:
 - Home health agencies
 - Imaging centers
 - Laboratories
 - Clinics
 - Medical spas
 - Small hospitals
 - Pharmacies
 - Nursing homes
 - Nurse practitioners
 - Physicians' assistants
 - Nurse anesthetists
 - Physical therapists
 - Pharmacists
 - Practitioners of alternative or complementary modalities
 - And many more
- Claims made form for professional liability exposures
- Claims made or occurrence general liability form for healthcare facility exposures
- Follow-form excess coverage available
- Physicians, dentists and podiatrists can be added as insureds
- Combined professional/general liability policy is available
- Incident sensitive coverage trigger
- High level product expertise long associated with Markel*
 - 30+ years underwriting and claim handling experience
 - Customized coverage suited to specific needs
 - Financial stability
 - Written through an affiliated A.M. Best "A" rated carrier



*Coverage available through Markel regional offices: Markel Mid South, Markel Midwest, Markel Northeast, Markel Southeast and Markel West. For information see our website at www.markelcorp.com. For complete terms and conditions, refer to the policy itself. Coverage is subject to exclusions in the policy.

2. EDUCATION/EXPERIENCE (Individual Applicant Only)

Institution Name and Address	Years of Training	Degree or Certification Attained
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

- (i) Where have you practiced your profession during the last ten years?
- In _____ From _____ To _____
- In _____ From _____ To _____
- In _____ From _____ To _____
- (ii) Have you ever failed any professional licensing or specialty organization examination? [] Yes [] No
 If yes, please attach a detailed explanation including the dates and location.

3. APPLICANT PRACTICE

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation. _____

b. Please indicate your professional specialty (CHECK ONE):

- | | | |
|--|--|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Naprapath | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Counselor (Describe)
_____ | <input type="checkbox"/> Nurse, Licensed Practical | <input type="checkbox"/> Physical Therapist |
| | <input type="checkbox"/> Nurse, Registered | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Nurses Registry | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Hearing Aid Fitter | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Speech Therapist |
| <input type="checkbox"/> Home Health Care Agcy. | <input type="checkbox"/> Optician | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Inhalation Therapist | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Visiting Nurse Assoc. |
| <input type="checkbox"/> Laboratory Technician | <input type="checkbox"/> Orthotist | <input type="checkbox"/> X-ray Technician |
| <input type="checkbox"/> Medical Personnel Pool | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Other (Specify) _____ |

c. Please indicate the sources and amounts of actual and projected revenue:

<u>Source</u>	<u>Amount This Fiscal Year</u>	<u>Amount Next Fiscal Year</u>
(i) Charitable Contributions:	\$ _____	\$ _____
(ii) Government Funding:	\$ _____	\$ _____
(iii) Fee for Services:	\$ _____	\$ _____
(iv) Other: _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

d. Please provide the number of patient or client visits:

<u>Type of Visit</u>	<u>Number of Visits Last 12 Months</u>	<u>Number of Visits Next 12 Months</u>
Clinic	_____	_____
Laboratory	_____	_____
Other (specify) _____	_____	_____
TOTAL NUMBER OF VISITS	_____	_____

e. Please specify any professional societies or associations in which you are a member: _____

f. Are you associated with or do you work for a physician or surgeon? [] Yes [] No
 If yes, please give the name and the specialty of the physician: _____

- g. Please give the approximate percentage of time spent in the following work locations:
- | | | |
|------------------------------------|---------------------------|--|
| _____ % Administrative Office | _____ % Laboratory | _____ % Hospital Ward (specify) |
| _____ % Classroom | _____ % Operating Room | _____ |
| _____ % Emergency Dept of Hospital | _____ % Outpatient Clinic | _____ % Professional Office (specify profession) |
| _____ % Nursing Home | _____ % Patient's Home | _____ |
| _____ % Other (specify) _____ | | |
- h. Please indicate the approximate division of your patients or clients among:
- | | | |
|---------------------------|----------------------|----------------------------------|
| _____ % Hemodialysis | _____ % Psychiatric | _____ % Bariatrics |
| _____ % Holistic Medicine | _____ % Drug Addicts | _____ % Physical Rehabilitation |
| _____ % Surgical | _____ % Alcoholics | _____ % Disability Evaluation |
| _____ % Stress Testing | _____ % Obstetrical | _____ % Research or Experimental |
| _____ % Communicable | _____ % Dental | _____ % _____ |
| _____ % Family Planning | _____ % Pediatric | _____ % _____ |
- i. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.
- | <u>Type of Profession</u> | <u>No.</u> | <u>Type of Profession</u> | <u>No.</u> |
|----------------------------|------------|---------------------------|------------|
| Inhalation Therapists | _____ | Opticians | _____ |
| Laboratory Technicians | _____ | Optometrists | _____ |
| Nurse Anesthetists | _____ | Perfusionists | _____ |
| Nurses, Licensed Practical | _____ | Pharmacists | _____ |
| Nurse Practitioner | _____ | Physiotherapists | _____ |
| Nurses, Registered | _____ | Social Workers | _____ |
| Speech Therapists | _____ | Other (please specify) | _____ |
- j. Are all of the above individuals licensed in accordance with applicable state and federal regulations? [] Yes [] No
If no, please attach an explanation.

4. APPLICANT PROCEDURES

- a. Do you render professional services directly to patients? [] Yes [] No. If yes, please describe in detail and indicate the extent of supervision by others.
- | <u>Description of Professional Services</u> | <u>Percent of Time Supervised</u> | <u>Qualifications of Supervisor</u> |
|---|-----------------------------------|-------------------------------------|
| _____ | _____ % | _____ |
| _____ | _____ % | _____ |
| _____ | _____ % | _____ |
- b. Do you render professional services that do not involve contact with a patient? [] Yes [] No. If yes, please describe these services in detail. _____
- c. (i) Do you perform or assist in any surgical procedures? [] Yes [] No
(ii) Please list ALL surgical procedures performed (including minor surgery): _____

- (iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others?
[] Yes [] No. If yes, please attach a detailed explanation.
- (iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility?
[] Yes [] No. If yes, please attach a detailed explanation.
- d. Do you perform radiation therapy? [] Yes [] No
- e. Do you perform psychiatric shock therapy? [] Yes [] No
- f. Do you compound in bulk, manufacture or wholesale medicine? [] Yes [] No
If yes, please provide a detailed explanation. _____

g. Do you own (wholly or in part), operate, or administer any hospital, nursing home or other institutions where medical services are customarily rendered? [] Yes [] No
 If yes, please give details including the name, location, size and number of beds.

h. If you have a training school, please complete the following. Attach a separate sheet if needed.

<u>Specify Profession For Which Students Are Being Trained</u>	<u>Max. No. Of Students Per Session</u>	<u>No. of Sessions Per Year</u>	<u>% of Time Involved in Clinical Setting</u>	<u>Number of Faculty</u>	<u>Qualifications of Faculty (e.g. MD, RN, PhD, etc.)</u>
--	---	---------------------------------	---	--------------------------	---

i. (i) Do you use a collection agency? [] Yes [] No
 If yes, please state the name of the agency

(ii) Does the agency have the authority to file a collection suit at its discretion? [] Yes [] No

7. APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any YES answers)

a. Have you or any of your employees:

- (i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? [] Yes [] No
- (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [] Yes [] No
- (iii) Ever been treated for alcoholism or drug addiction? [] Yes [] No
- (iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refuses or accepted only on special terms or ever voluntarily surrendered same? [] Yes [] No
- (v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? [] Yes [] No

b. Please list prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

<u>Policy Insurance Carrier</u>	<u>Policy Number</u>	<u>Limits of Liability</u>	<u>Deductible (If any)</u>	<u>Premium</u>	<u>Inception Mo./Day/Yr.</u>	<u>Expiration Mo./Day/Yr.</u>	<u>Was this a Claims Made Policy Form?</u>		<u>Retro Date</u>
							<u>Yes</u>	<u>No</u>	
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____

- c. Does the Applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? [] Yes [] No
- d. Has any claim or suit been brought against you and/or any of your employees? [] Yes [] No
 If yes, a Supplemental Claim Information Form must be completed for each claim or suit.
- e. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? [] Yes [] No
 If yes, please give details on a separate sheet.

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

PLEASE COMPLETE FOR THE FOLLOWING SERVICES:

Phlebotomy Number of annual draws: _____ Revenue: _____

First Aid Training Number of training sessions: _____ Revenue: _____

CPR Training Number of training sessions: _____ Revenue: _____

Flu Shots Number of flu shots: _____ Revenue: _____

Inoculations Number of inoculations: _____ Revenue: _____

Physical Examinations Number of Examinations: _____ Revenue: _____

Do you want to include the MD? Yes No

If yes, is the MD a W2 Employee or 1099 Contractor? W2 Employee 1099 Contractor

If yes, please provide a copy of current CV and license for the MD

If no, please provide a Certificate of Insurance from the MD

This policy may be audited at expiration.

BB&T INSURANCE SERVICES, INC.

110 Dixie Street

Carrollton, GA 30117

The office insurance program

Protection for the needs of office-based businesses

Not all office-based businesses are the same. They can be big or small, with a few or many employees. What they have in common is the right insurance protection that's there when needed. Zurich Small Business® designed its office insurance program to meet the unique circumstances most offices face — with the flexibility to combine additional coverages tailored specifically for your business.

With the extensive coverage from Zurich Small Business, you can combine property, liability, commercial auto, umbrella — and one of the top written workers' compensation coverages in the country.

And we don't stop at products. Top-notch claims services, risk management and industry-leading technology make Zurich Small Business the one-stop insurer for office-based businesses.

Coverage highlights include:

- Buildings and structures
- Newly acquired or constructed buildings
- Business income and extra expense
- Glass breakage
- Backup of sewers and drains
- Outdoor property

Small business is our business.

Workers' Compensation

Workers' compensation coverage from Zurich Small Business protects your employees for work-related injuries and includes access to a wide network of claims professionals, registered nurses, bill review specialists, vendor managers, fraud investigators and help line personnel. These services help employees receive quality medical care while reducing the overall cost of the medical expenses that affect your premium.

Commercial Auto

We understand how difficult it could be on your business if one of your commercial vehicles is out of service for repair or replacement. Zurich Small Business commercial auto coverage provides prompt, responsive and fair service. Our ultimate goal is to minimize your business disruption by getting your automobiles repaired and back on the road as quickly as possible.

Supportive services to help round out your Zurich Small Business experience

Risk engineering services — understanding risk across your business
Our risk engineering solutions — tools, reports and information from literally millions of past claims from nearly every industry segment — can help small businesses minimize and better control losses and improve their bottom line.

Responsive claim service

We view the claims process as an opportunity — An opportunity to honor our commitment to office-based business owners, to prove our knowledge of the challenges you face in running a successful small business. Our fast and responsive claims service can help minimize your business disruption and get you back to full operation as quickly as possible.

Strong, supportive protection from Zurich Small Business

Operating a business is hard work and worrying about your insurance protection should not be a major concern. Let us put our financial strength, considerable experience and commitment behind your business.

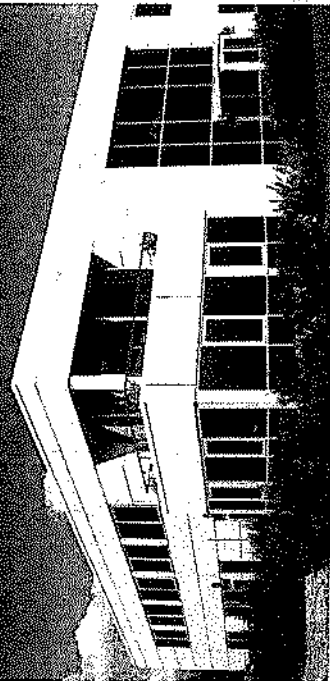
Independent agents

Our broad network of independent agents across the country stands ready to help you with professional insurance advice. Ask your independent agent today about the Zurich Small Business office insurance program.

Coverage specifically designed for office-based businesses

Zurich Small Business® understands the unique needs of an office-based business and offers flexibility in creating the coverage plan you want. To make the policy work for your business, we offer you a range of customizable options.

- **Professional liability** – Insurance protection against claims of negligence or malpractice for some classes.
- **Accounts receivable coverage** – Provides insurance against losses caused by damage to your records, which may prevent you from collecting funds owed by customers.
- **Business income loss protection** – Insurance protection against loss of income for up to 12 months and pays the full cost of necessary extra expenses to help you stay in business.
- **Employee dishonesty coverage** – Available in amounts from \$10,000 to \$250,000 to help protect you from the dishonest acts of employees.
- **Electronic data processing equipment coverage** – A base level of coverage is built into the policy. You have the option to increase that level or schedule high value items separately.
- **Business personal property coverage** – Insurance protection against loss concerning your business's personal property and the property of your customers while it is in your care, custody and control.
- **Valuable papers coverage** – Insurance for the cost to restore information from documents, such as medical or legal records, deeds or abstracts.



For more information, contact your local Zurich Small Business Independent Agent.

ZURICH Small Business®

Zurich Small Business
3003 Summit Blvd, 8th Floor
Atlanta, GA 30319
1-800-800-3367
www.zurichna.com

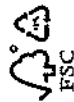
This is intended as a general description of certain types of insurance and services available to qualified customers through the companies of Zurich in North America.

Your policy is the contract that specifically and fully describes your coverage. The description of the policy provisions gives a broad overview of coverages and does not revise or amend the policy.

Insurance coverages underwritten by member companies of Zurich in North America, including Zurich American Insurance Company. Certain coverages not available in all states. Some coverages may be written on a nonadmitted basis through surplus lines brokers.

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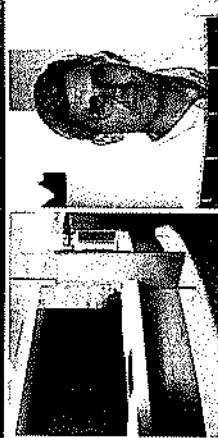
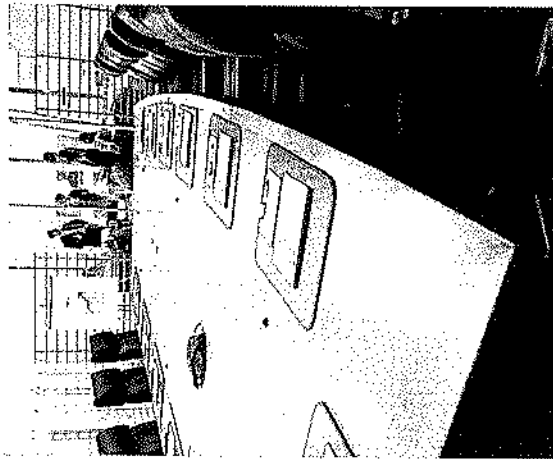
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Alfred Sources
Member of the Zurich Group
100 North Main Street, Suite 1111
New York, NY 10038
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ZURICH

Small Business®



The Office Insurance Program

Insurance protection
for office-based businesses

PROPERTY

(if more than one building, please make a copy and submit for each)

Building Limit: _____

Business Personal Property: _____

Construction of Building:
(Needed if owned or leased) _____

Type Roof: _____

Square Footage:
(Needed if owned or leased) _____

Year Built
(if over 20 years, need date Roof, Electrical, Plumbing & HVAC updated)
(Needed if owned or leased) _____

Inside/Outside City Limits? Inside Outside

Distance from fire department: _____

Sprinklered? Yes No

Type Alarm: _____

Smoke Detector? Yes No

MOBILE EQUIPMENT (Goes off premises)

Year	Make	Model	Limit
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GENERAL LIABILITY

Current Carrier: _____

Desired Limits of Liability (\$1,000,000 is standard): _____

Sales/Revenue: _____

Payroll: _____

WORKERS COMPENSATION

Employees: ____ # Clerical employees: ____ # Owners/Officers: ____

Employee Duties	Payroll	# Part Time	# Full Time
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Individuals, Partners, & Officers Information – (Not listed above)

Name	Title	Ownership %	Duties	Include or Exclude	Payroll
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

AUTOMOBILE

DRIVER NAME	DATE OF BIRTH	DRIVERS LICENSE #	STATE LICENSED	ANY ACCIDENTS OR VIOLATIONS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

YEAR	MAKE	MODEL	ID NUMBER	GROSS VEHICLE WEIGHT	USAGE
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

LIABILITY LIMIT: _____
 UNINSURED MOTORISTS LIMIT: _____
 MEDICAL PAYMENT LIMIT: _____
 COLLISION DEDUCTIBLE: _____
 OTHER THAN COLLISION DEDUCTIBLE: _____

WHICH VEHICLES DO YOU WANT "COLLISION" & "OTHER THAN COLLISION" QUOTED ON?

1. Are driver's allowed to take vehicles home? [] Yes [] No

LYNN DEBNAM (877) 643-6227 toll-free #1 then # 38
BB&T Insurance Services, Inc. (919) 716-9956 direct
PO Box 31128 (888) 831-8413 fax
Raleigh, NC 27622 ldebnam@bbandt.com
 Page 3 of 3 (Commercial Lines Supplemental Application) **CONFIDENTIAL**



Why You Need Employment Practices Liability Insurance (EPL)

WHY YOU NEED EPL:

- ▶ In 2008, charges against employers for discrimination were up 15.2%; charges of harassment were up 20% and charges of retaliatory treatment were up 22.6%.
- ▶ The legal landscape for employers continues to change with the passage of laws like the Lilly Ledbetter Fair Pay Act of 2009 and the Americans with the Disabilities Act Amendments Act of 2008.
- ▶ Layoffs, downsizings, salary freezes and reductions in benefits can be used by past and present employees as evidence of "tangible adverse employment actions" to file charges of discrimination, harassment, retaliation and wrongful termination against employers.

WHAT CAN YOU DO TO PROTECT YOURSELF?

- ▶ Purchase EPL coverage from an A++ rated professional liability insurance company.
- ▶ As you do with all insurance, look at the cost of transferring the risk:
 - \$150,000 = the average cost of defense
 - \$250,000 = the average jury award if the case goes to a verdict
 - \$???,??? = settlements are private and not a matter of public record

WHAT COVERAGE ARE WE OFFERING?

COVERAGE FEATURES	OUR GROUP	COMPETITORS' POLICY
Broad definition of Wrongful Employment Act - We cover Discrimination, Harassment, Retaliation, Wrongful Termination, Workplace Torts and negligent violations of certain employment laws.	✓	?
\$100,000 Sub-limit for Defense and Loss for Wage-and-Hour Claims (not available in CA and FL or on accounts with prior claims)	✓	?
Unlimited Defense Costs Outside the Limit (for accounts with up to 200 employees if a limit of \$500,000 or greater is chosen)	✓	?
Duty to Defend - We investigate, defend and, with your consent, negotiate the settlement of any Claim.	✓	?
Risk Management Service – toll free hotline plus online HR toolkit	✓	?

IF YOU HAVE ELECTED NOT TO PURCHASE EPL COVERAGE, PLEASE READ AND SIGN BELOW.

1. We acknowledge that our agent has fully explained the potential employment practices liability risks associated with the operation of our company/organization.
2. We understand that we have the option of purchasing employment practices liability insurance that can protect our company/organization against the potential for significant monetary loss, including cost of defense from employment practices liability claims. We further acknowledge that our agent has recommended that we purchase the coverage and has provided us with one or more quotes for same.
3. We understand that by electing not to purchase such insurance, we are foregoing valuable protection which means our company/organization will be responsible for paying the cost of defending and settling any and all employment practices liability claim(s) made against us.

NAME			
TITLE		Date	
SIGNATURE			



Check Out Your New Employment Practices Liability Risk Management Toolkit from PeopleSystems

FREE EMPLOYMENT PRACTICES LIABILITY (EPL) HELP LINE

1-888-____-_____
(Toll free number to be released with the policy)
(8:00AM to 7:30PM Eastern time)

If a Human Resource (HR) consulting firm offered you their time and expertise for **FREE**, would you lock their phone number and email address in a drawer and never call? Of course not! Do you have questions such as:

- ▶ What are the current Federal and state employment laws I need to know?
- ▶ What are "wage & hour" regulations? What does "exempt" versus "non-exempt" mean?
- ▶ How should I handle terminating, suspending or warning an employee?
- ▶ What type of HR policies should I have in place?
- ▶ How should I properly document performance issues and disciplinary actions in an employee's file?
- ▶ What are appropriate and inappropriate questions to ask during an employment interview?
- ▶ What guidelines should I use to investigate a complaint of discrimination or harassment?

PeopleSystems is just a **FREE** phone call or email away!

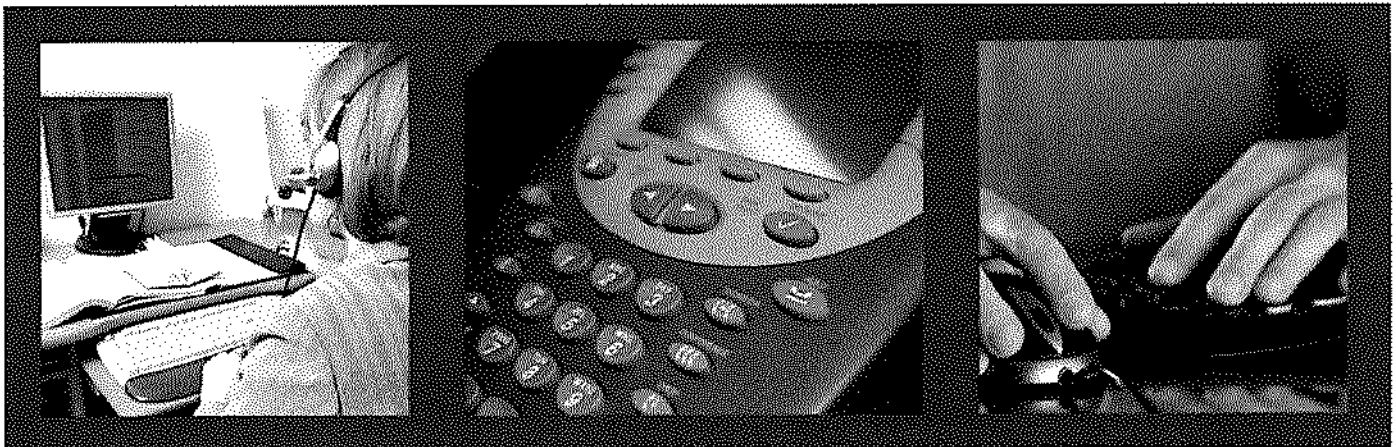
ONLINE HUMAN RESOURCES CENTER

<http://www.peoplesystems.com/USLI>

(Only policyholders may request login)

Please take a moment to become familiar with the PeopleSystems' Resource Center's content.

- ▶ [Helpline to e-mail your HR questions](#)
Now you can email your questions via this web portal.
- ▶ [HR News Center and recent employment law changes](#)
The News Center keeps you up to date with recent changes in state and federal employment laws and what they mean to you as well as pertinent articles on employment issues you need to know about.
- ▶ [Human Resource Manual & Employment forms](#)
You will find a helpful how-to guide for writing an employment procedures manual, doing employee evaluations and following employment laws such as FLSA, FMLA and COBRA.
- ▶ [HR Recommendations](#)
You will also find sample HR policies regarding Discrimination, Harassment, Employment At-Will and Electronic Communications.





Employment Practices Liability Application - All States

This application is for a Claims Made policy. Please read your policy carefully. Defense costs shall be applied against the retention. Applicant may qualify for an INSTANT QUOTE by completing Section I below. Section II answers will be required prior to binding and are subject to underwriting approval.

I. INSTANT QUOTE INFORMATION
 Instant quote is not available for accounts with losses in the past 5 years. If there is a loss history, please complete Section I and submit details in a claim supplement.

Applicant's Name: _____

Location Address: _____ Same as mailing address

City: _____ State: _____ Zip: _____

Web Address: _____

Email Address of primary contact: _____

Description of Operations:

Full time employees _____ Part time _____ Temporary/ Seasonal _____ Independent Contractors _____ Leased _____

How many of the above are located in: California _____ Florida _____ Louisiana _____ Outside the U.S. _____

II. UNDERWRITING INFORMATION

- Year Established: _____
- Do more than 50% of all employees currently earn more than \$100,000? Yes No
- a) Is the Applicant a Subsidiary of another organization? Yes No
 b) Is the Applicant a franchisee of another organization? Yes No
 c) Name of Parent and/or Franchisor and Location _____
- Does the Applicant want any Subsidiary(s) covered? If "Yes," include employees in employee count above and provide: Yes No
 a) Name of Subsidiary(s) _____
 b) Is the Subsidiary(s) at least 50% owned by the Applicant? Yes No
 c) Does the Subsidiary(s) fall within the same class of business as the Applicant? Yes No
- Expiring Policy: Retroactive Date _____ Carrier _____ Limits _____ Retention _____ Premium _____
Written Guideline Requirements:
 a) Does each entity proposed for insurance have a written Email/Internet Policy currently in place or is willing to implement one? Yes No
 b) Does each entity proposed for insurance have a written Anti-Discrimination and Anti-Harassment Policy currently in place? Yes No
 (Attach a statement of details for all "yes" answers to the following questions)
- a) Has any entity proposed for insurance closed, sold, merged-with or acquired any company in the past 12 months or anticipate doing so in the next 12 months? Yes No
 b) Has any entity proposed for insurance downsized, laid off, or reduced staff in the past 12 months or anticipate doing so in the next 12 months? Yes No
 If "Yes," what percentage of the workforce was/will be affected? _____
- Within the last 5 years, has any employment related, or third party discrimination, or third party harassment inquiry, complaint, notice of hearing, claim, or suit been made against any entity proposed for Insurance or any person proposed for Insurance in the capacity of either Director, Officer, Member (if an LLC), or Employee of any entity proposed for Insurance? If "Yes" complete USLI Claim Supplement for each claim Yes No
- Is any person proposed for this Insurance aware of any fact, circumstance, or situation which may result in an employment claim, or third party discrimination, or third party harassment claim against any entity proposed for Insurance or any of its Directors, Officers, Members (if an LLC), or Employees?
 If "Yes," complete USLI Claim Supplement for each claim Yes No
- Has any Policy for Employment Practices Liability insurance ever been cancelled or non-renewed by the carrier? Yes No
 (Do not answer if applicant is located in Missouri)

III. ADDITIONAL APPLICANT INFORMATION

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

Arizona Notice: Misrepresentations, omissions, concealment of facts and incorrect statements shall prevent recovery under the policy only if the misrepresentations, omissions, concealment of facts or incorrect statements are; fraudulent or material either to the acceptance of the risk, or to the hazard assumed by the insurer or the insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

Florida and Illinois Notice: I understand that there is no coverage for punitive damages assessed directly against an insured under Florida and Illinois law. However, I also understand that punitive damages that are not assessed directly against an insured, also known as "vicariously assessed punitive damages", are insurable under Florida and Illinois law. Therefore, if any Policy is issued to the Applicant as a result of this Application and such Policy provides coverage for punitive damages, I understand and acknowledge that the coverage for Claims brought in the State of Florida and Illinois is limited to "vicariously assessed punitive damages" and that there is no coverage for directly assessed punitive damages.

Minnesota Notice: Authorization or agreement to bind the insurance may be withdrawn or modified only based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for nonpayment of premium.

Missouri & Rhode Island Disclosure Notice: I understand and acknowledge that if a \$100,000 or \$250,000 Limit of Liability is chosen or if the Insured Organization has more than 200 employees, that Defense Costs are a part of the Limit of Liability. This means that Defense Costs will reduce my limits of insurance and may exhaust them completely and should that occur, I shall be liable for any further legal Defense Costs and Damages. Defense Costs are as defined in Section III. I also understand that the Limit of Liability for the Extended Reporting Period, if applicable, shall be a part of and not in addition to the limit specified in the Policy Declarations.

New York Disclosure Notice: This policy is written on a claims-made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged Wrongful Acts or Wrongful Employment Acts that took place prior to retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect for incidents reported during the Policy Period or any subsequent renewal of this Policy or any extended reporting period and all coverage under the policy ceases upon termination of the policy except for the automatic extended reporting period coverage unless the insured purchases additional extend reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The Insured may purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.

Utah Notice: I understand that Punitive Damages are not insurable in the state of Utah. There will be no coverage afforded for Punitive Damages for any Claim brought in the State of Utah. Any coverage for Punitive Damages will only apply if a Claim is filed in a state which allows punitive or exemplary damages to be insurable. This may apply if a Claim is brought in another state by a subsidiary or additional location(s) of the Named Insured, outside the state of Utah, for which coverage is sought under the same policy.

Virginia Notice: This Policy is written on a claims-made basis. Please read the policy carefully to understand your coverage. You have an option to purchase a separate limit of liability for the extended reporting period. If you do not elect this option, the limit of liability for the extended reporting period shall be part of the and not in addition to limit specified in the declarations. If you have any questions regarding the cost of an extended reporting period, please contact your insurance company or your insurance agent. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

Colorado Fraud Statement: 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 Fraud Statement: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Fraud Statement: You are agreeing to place coverage in the surplus lines market. Superior coverage may be available in the admitted market and at a lesser cost. Persons insured by surplus lines carriers are not protected under the Florida Insurance Guaranty Act with respect to any right of recovery for the obligation of an insolvent unlicensed insurer.

Kentucky Fraud Statement: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine and Washington Fraud Statement: 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 a denial of insurance benefits.

New Jersey Fraud Statement: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York Fraud Statement: 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 Fraud Statement: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Fraud Statement: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania Fraud Statement: 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 subjects such person to criminal and civil penalties.

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

Vermont Fraud Statement: 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 subject to fines and confinement in prison.

Fraud Statement (All Other States): 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.

If your state requires that we have information regarding your Authorized Retail Agent or Broker, please provide below.

Retail Agency Name: _____ License #: _____

Agent's Signature: _____ Main Agency Phone Number: _____
(Required in New Hampshire)

Agency Mailing Address: _____
City: _____ State: _____ Zip: _____

The signer of this application acknowledges and understands that the information provided in this Application is material to the Insurer's decision to provide the requested insurance and is relied on by the Insurer in providing such insurance. The signer of this application represents that the information provided in this Application is true and correct in all matters. The signer of this Application further represents that any changes in matters inquired about in this Application occurring prior to the effective date of coverage, which render the information provided herein untrue, incorrect or inaccurate in any way will be reported to the Insurer immediately in writing. The Insurer reserves the right to modify or withdraw any quote or binder issued if such changes are material to the insurability or premium charged, based on the Insurer's underwriting guides. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the Policy.

Applicant's Signature: _____ Title: _____ Date: _____
President, Chairperson of the Board, Managing Member, or Executive Director