

EMPLOYEE BENEFITS LIABILITY APPLICATION

COVERAGE ON A CLAIMS-MADE BASIS

1. Named Insured: _____

Address: _____

2. Proposed policy Period: _____ To _____

3. Proposed Retroactive Date: _____

4. Deductible: \$ _____

5. Number of Employees: _____

6. Limit of Insurance: _____ Each Employee _____ Aggregate

7. Losses and Known Acts, Errors or Omissions, which may result in claims being made under this Insurance (Last 5 Years):
(if none state "None")

8. Employee benefits provided. Mark with an "I" for insured plans and use an "S" for Self-funded or Self-Insured Plans.

_____ Group Life	_____ Unemployment Insurance
_____ Group Accident	_____ Social Security Benefits
_____ Group Health	_____ Workers Compensation
_____ Group LTD	_____ Disability Benefits
_____ Group Profit Sharing Plans	_____ (required by States)
_____ Pension Plans	_____ Stock Subscription Plans*

* Explain eligibility for Stock Subscription Plans

9. Name and title of the person who has responsibility for the management of your employee benefit program.

a. Number of years in this position _____

b. Number of years experience in the administration of benefits plans _____

10. Are all Personnel who counsel employees about benefits familiar with the details of the programs shown in Item 8. above? _____

11. Are all Personnel who counsel employees about benefits familiar with COBRA Requirements? _____



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12. Are all programs in compliance with COBRA Requirements? _____
Please explain any "no" responses: _____

13. Do you administer any benefits plans for others? _____
If "yes", please explain: _____

14. Have you rejected the Workers Compensation Acts in any states? _____
If yes, which states? _____
Do you offer alternative benefits packages in those states? _____
If yes, please describe _____

PLEASE NOTE: YOUR EMPLOYEE BENEFITS LIABILITY POLICY DOES NOT APPLY TO:

- a. Taxes, fines or penalties imposed under the Internal Revenue Code or any similar state or local law; or
- b. Loss or damages arising out of the imposition of such taxes, fines or penalties.

I have carefully examined the foregoing statements and warrant that such statements constitute a full, complete and accurate disclosure of all facts and further warrant that to the best of my knowledge, there are no undisclosed losses, acts, omissions, or errors that will result in any claims under this insurance.

GENERAL FRAUD STATEMENT

[NOT APPLICABLE IN CO, HI, NE, OH, OK, OR, IN]

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSES OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. [ME AND VA: INSURANCE BENEFITS MAY ALSO BE DENIED].

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 services.

HAWAII

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

OHIO

Any person who, with intent to defraud or knowing that he/she 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.

This notice is given as required by the laws of the State of Ohio.

_____ **Date** _____

Named Insured or Authorized Officer

Title _____ **Agent's Signature** _____