



Employment Practices Liability Insurance

Premium Indication

This information may be used to provide one or more indications (rough estimates) of premium for your organization. A more detailed application will need to be completed and reviewed in order to determine acceptability and to provide a quotation. If applicant has been involved in any claim or suit or is aware of any incident which may give rise to a claim, a full application or Supplemental Claim Form must be completed. Please complete and return this form to Tennant Risk Services for a premium indication.

Applicant: _____

Contact: _____

Tel: _____ eMail: _____

Address: _____

Primary business activities: _____

Date Established: _____ Total Revenue: \$ _____ Website: _____

Type: Corporation LLC/Partnership Other: _____

Full-Time Employees: _____ Part-Time Employees: _____ (Part time less than 20 hrs/week)

Temporary: _____ Seasonal: _____ Independent Contractors _____ (may not be covered): Total _____

Maximum annual percent employee turnover in any of the last 5 years: _____ % (**Answer Required!**)

- Do more than 25% of all employees earn more than \$50,000 incl. bonuses/commission? Yes No
- Do you publish and distribute an Employee Handbook to every employee? Yes No
- Do you utilize an employment application stating the employment relationship is "at will?" Yes No
- Have all managers, supervisors and officers attended sexual harassment training w/in the last 18 months? Yes No
- Do you have a separate personnel or human resources department? Yes No
- Do you maintain a personnel file for each employee? Yes No
- Does the applicant have written procedures for handling grievances or complaints, including discrimination and sexual harassment? Yes No

Total number of employment-related allegations, claims or suits in last 5 years: _____ in the last 12 months: _____

Total number of EEOC/state agency charges filed in last 5 years: _____

Do you currently have Employment Practices Coverage? Yes No

Carrier: _____ Renewal Date: _____ Premium: _____

Limits: _____ Deductible: _____ Retrodate: _____

Insurance Agency: _____

Agency Contact: _____

Phone: _____

eMail: _____