

RENEWAL APPLICATION FOR EDUCATORS LEGAL LIABILITY INSURANCE

NOTICE: This insurance contains claims-made coverage. This insurance is limited to liability for acts, errors or omissions for which claims are first made against the insured while the insurance is in force. Please read and review the insurance carefully and discuss the coverage with your insurance agent.

1. GENERAL INFORMATION

a) Applicant _____

Person to Contact _____
 Title _____ Phone _____

	CURRENT YEAR	NEXT YEAR ESTIMATE
Number of Students		
Number of Full-time Employees		
Number of Part-time		

* Full-time employees are employees hired to work at least 35 hours per week on a regular basis.

** Part-time employees include any seasonal, temporary, contract or leased employees.

2. FINANCIAL/BOND INFORMATION

a) Budget:

	YEAR	REVENUES	EXPENDITURES	SURPLUS (+) DEFICIT (-)
Current Year:				
Last Year:				

b) If surplus/deficit exists, indicate use of surplus or cause of deficit and how it will be eliminated.

c) Do you expect a budget reduction in the next year? Yes No

d) What is entity's current bond rating: _____

3. OPERATIONAL/ADMINISTRATIVE INFORMATION

a) Have you had on-site monitoring visits by State or Federal Regulatory Agencies in the past year? Yes No

If "Yes", provide name of Agency and purpose of visit: _____

- b) In the past year, have you been involved in any school mergers/closings or plan to do so in the next 18 months? Yes No
- If "Yes", has your attorney reviewed your staff reduction plan? Yes No
- If "Yes", explain _____
- c) Any school openings in the next 18 months? Yes No
- If "Yes", explain: _____
- d) Did any of the following take place in the past year? **Explain all "Yes" answers below.**
- 1) Strike slowdown or other disruptions? Yes No
- 2) Disputes involving integration, segregation, discrimination or violations of civil rights? Yes No
- 3) Has any employee been suspended, dismissed, demoted, transferred or tenure contract nonrenewed? Yes No
- Explanation for any "yes" answers: _____
- e) How many hearings/appeals have taken place in the past year? _____
- In what areas: _____
- f) How many hearings/appeals from **3.e)** above are in the area of special education? _____
- g) How many employees have resigned, been terminated (with or without cause) or retired:
 Current Year _____ Prior Year _____

4. PAST CLAIMS ACTIVITIES

Claims History, Incidents, Insured/Uninsured Losses—Current and Past Year

- a) Has any person, former employee or job applicant made claim alleging unfair or improper treatment regarding hiring, salary, advancement, demotion, suspension or termination that has not been reported to the carrier? Yes No
- b) Has entity been criticized by the state board of education in the past year? Yes No
- c) Is the entity operating under a court's supervision? Yes No
- If "Yes", provide details: _____
- d) Has any claim been presented in the past year or is now pending against any person in his/her official capacity as an official, employee or volunteer of the entity, that has not been presented to the carrier? Yes No
- e) Have there been any written or oral demands or claims made in the past year to your human resource department, internal legal division or department, or any department that provides a human resource function or to the Superintendent of Schools, Assistant Superintendent of Schools, Principals, or Vice Principals that have not been presented to the carrier? Yes No

If any of the answers to the prior questions is "Yes", please complete the Supplemental Claims Information Form.

The following must be attached to this application only if applicable:

1. Any updates to the Employee Handbook
2. EEO-5 Report filed in the last two (2) years

Declaration and Signature

Authorized Entity Representative Designation

The person named herein is authorized and designated to give and receive any and all notices on behalf of the entity and all insureds from the entity or their authorized representative(s) concerning this insurance.

Named Individual: _____ Title or Position: _____

Entity's Attestation

The authorized signer of this application represents to the best of his or her knowledge and belief that the statements set forth herein are true and include all material information. The authorized signer also represents that any fact, circumstance or situation indicating the probability of a claim or action now known to any entity, official or employee has been declared, and it is agreed by all concerned that omission of such information shall exclude any such claim or action from coverage under this insurance. Signing of this application does not bind the Company to offer nor the authorized signer to accept insurance, but it is agreed this application and any attachments thereto shall be the basis of the insurance.

Signature of Authorized Entity Representative

_____ Date: _____

The following statements are required by the regulations of the following state Insurance Departments. It is a requirement of certain states that this signed statement be attached to the policy. Please read the statement applicable to your state and sign where indicated.

CALIFORNIA APPLICANTS: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT SIGNATURE _____ DATE _____

FLORIDA APPLICANTS: PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

KENTUCKY APPLICANTS: 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 FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICANT SIGNATURE _____ DATE _____

MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MINNESOTA APPLICANTS: A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT SIGNATURE _____ DATE _____

NEW YORK APPLICANTS: 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 FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE D VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

APPLICANT SIGNATURE _____ DATE _____

OHIO APPLICANTS: 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.

APPLICANT SIGNATURE _____ DATE _____

OKLAHOMA APPLICANTS: 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 APPLICANTS: 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 A PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT SIGNATURE _____ DATE _____

UTAH APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT UNDERWRITING INFORMATION, FILES OR CAUSES TO BE FILED A FALSE OR FRAUDULENT CLAIM FOR DISABILITY COMPENSATION OR MEDICAL BENEFITS, OR SUBMITS A FALSE OR FRAUDULENT REPORT OR BILLING FOR HEALTH CARE FEES OR OTHER PROFESSIONAL SERVICES IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

SUPPLEMENTAL CLAIMS INFORMATION

Complete this page only if there are any "Yes" answers in Section 4. **PAST CLAIMS ACTIVITIES** of this application.

Date of Claim: _____

Date of the earliest alleged fact or circumstances giving rise to the claim: _____

Name of the Plaintiff (Complainant): _____

Name of all Defendants (Respondent): _____

Forum for the Claim: _____

Name of Counsel selected to defend the Claim: _____

Have any loss payments been made on behalf of the company or any of its employees under any Employment Practices policy or similar insurance:

A brief description of the allegations contained in the claim (if additional space is required, attach additional sheet):

Amount spent to date in defense of the claim: _____

Amount of any settlement or judgment within the deductible: _____

Current Status: