SUPPLEMENTAL APPLICATION
FOR INCREASED LIMITS FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE

Applicant: _____ Dentist's Advantage Policy No. _____

Phone: ( ) _____ Fax: ( )_____ Email : _____

1. Are all office locations under direct control of the applicant? ☐ Yes ☐ No

   If "No", attach full details.

2. Operating as: ☐ Individual ☐ Partnership ☐ Corporation Date business established*: _____

   * If in operation less than three years, furnish detailed explanation with prior insurance experience.

3. Total number of employees: _____ Total number of dentists: _____

4. Do you have a Personnel/Human Resource Department: ☐ Yes ☐ No

   If "Yes", number of staff: _____
   If "No", who is responsible for this function and what are that person's qualifications?
   _____

5. a. Do you have an employee handbook or manual?

   If "Yes", is it updated regularly? ☐ Yes ☐ No
   If "Yes", is it issued to every employee? ☐ Yes ☐ No

   b. Does it address: Sexual harassment? ☐ Yes ☐ No
   Discrimination? ☐ Yes ☐ No
   Termination grounds and procedures? ☐ Yes ☐ No

   c. Has it been reviewed by an attorney? ☐ Yes ☐ No

6. Have you instructed or trained employees responsible for hiring, including managers and supervisors, on discrimination and sexual harassment issues? ☐ Yes ☐ No

7. Are medical records kept separate from other personnel records and secured in locked file cabinets? ☐ Yes ☐ No

   If "No", please explain how you maintain confidentiality:
   _____
   _____

8. Are qualifications/skill tests required of job applicants? ☐ Yes ☐ No

   If "Yes", are arrangements made to accommodate the disabled? ☐ Yes ☐ No

9. Have written emergency and/or evacuation procedures been reviewed to ensure that the needs of the disabled have been considered? ☐ Yes ☐ No

10. Do you use private employment agencies to recruit job applicants? ☐ Yes ☐ No

    If "Yes", have you explained to them in writing they must comply with the Americans with Disabilities Act? ☐ Yes ☐ No

11. Is any person or persons in your organization responsible for Americans with Disabilities Act compliance, including public accommodations issues and employment-related functions? ☐ Yes ☐ No

If "Yes", provide names, titles, duties and to whom they report:

_____

_____

12. Have you reviewed policies, practices and procedures to determine compliance with the Americans with Disabilities Act? ☐ Yes ☐ No

If "Yes", please explain the review procedure:

_____

_____

13. Does your place of business comply with current Uniform Federal Accessibility Standards? ☐ Yes ☐ No

If "No", please attach details about the type of accessibility review your place of business has undergone.

_____

_____

14. Are all federal/state mandated posters conspicuously displayed? ☐ Yes ☐ No

15. Have any staff members been terminated in each of the last three years? ☐ Yes ☐ No

If "Yes", please advise the number of employees terminated and the basis for termination:

_____

_____

16. Please provide a separate attachment with full details on all Wrongful Termination, Discrimination and Sexual Harassment claims as well as administrative proceedings made against the Applicant or any of its directors, officers or employees. Describe the type of allegation, the court or agency involved, and any determination, judgment, defense cost or settlement for each. (If no such claims, check here [ ] None.)

17. Are you aware of any circumstances other than those listed in Question 16. which might give rise to a claim under this policy? ☐ Yes ☐ No

If "Yes", attach details.

Prior Insurance

18. List prior employment practices liability insurance detail for past five years. (If none, check here [**]** **None**.)

Insurer	Limits	Deductible	Policy Period
_____	$_____	$_____	_____

19. Have you had any similar coverage canceled during the last five years? ☐ Yes ☐ No

If "Yes", please explain:

_____

_____

_____

Requested Coverage

20. a. Limit Desired: [ ] $100,000 [ ] $250,000 [ ] $500,000 [ ] $750,000

b. Deductible: [X] $2,500 (Mandatory)

c. Desired Effective/Retroactive date: _____

EMPLOYMENT PRACTICES LIABILITY INSURANCE SUPPLEMENTAL INFORMATION

Refer to Item Number

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Applicant hereby represents that the statements and answers to questions made above and attachments hereto are true, and applicant has not omitted or misrepresented any information.

Further, Applicant understands and agrees that they are to report any changes in the information provided in this application that occur after the date of the application.

Signed by Authorized Representative: _____

Date: _____ Title: _____