Employee Benefits Liability Questionnaire

I. APPLICANT INFORMATION						
Named Insured:			Effective Date:			
Names of Any Subsidiary Organizations:						
1. 4.						
2. 5. 6.						
	T.	<u> </u>	1			
Location Address	Street:	City:	State:	Zip:		
II COVE	PAGE AND LIMITS OF LIABILITY					
II. COVERAGE AND LIMITS OF LIABILITY						
Coverage Type: Claims Made Occurrence Limits of Liability: \$ Each Claim/ \$ Aggregate						
	A deductible of \$1000 Each Claim will apply.					
Retroactive Date/						
III. QUES	STIONNAIRE					
Does the Applicant have an official full-time personnel department and/or a designated benefits administrator?				☐ Yes ☐ No		
2. Is the Benefit Program audited annually?						
If No, how often?						
3. Are employees required to review their benefit elections at least annually?						
4. Does the Applicant have an EEOC policy?						
5. Indicate the method by which the Employee Benefit Program is presented to Employees: ☐ Verbally at time of employment ☐ Outlined in a printed pamphlet ☐ Verbally and by printed pamphlet						
6. Are the same benefits offered to all regular, full time employees?			☐ Yes ☐ No			
7. Do employees acknowledge by signature that benefits were reviewed with them?				☐ Yes ☐ No		
8. Is a signed acceptance/rejection form kept in the employee personnel file?						
9. List the Benefits available to employees and indicate the approximate time when eligible:						
	<u>Benefit</u>		When eligibl	<u>e</u>		
10. When Benefits become available at a date subsequent to employment, what controls are established to assure that employee is again contacted?						
l .	ployees who are leaving the company eligible for group f Yes, what are the procedures for notifying the employ		RA" Law?	☐ Yes ☐ No		

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12. Employee Totals: a. Number of Employees at main location: b. List branch location 1. 2. 3. 4. 5. Total Number of Employees: Stanch Location	III. QUESTIONNAIRE (Continued)			
b. List branch location and number of employees: Branch Location 1. 2. 3. 4. 5. Total Number of Employees:	12. Employee Totals:	Number of Employees	Number of Employees	
1. 2. 3. 4. 5. Total Number of Employees: 13. Is any hiring of employees done in branch offices? a. If Yes, by what means does the personnel department exercise control over the counseling of employees with respect to the Benefit Program? b. Where are branch records maintained? 14. Is Workers Compensation in force and being provided by an "A" rated carrier? 15. Does the operation involve any of the following: a. Major Occupational Disease exposure? b. Significant % of seasonal work? c. High employee Benefits Coverage been carried in the past? If Yes, provide the following: a. Name of carrier b. Expiration date c. Retroactive date 17. Are there any claims, demands or legal proceedings pending against the Insured on related to any act of negligence, error, mistake or omission in the handling of an Employee Benefit Program: If Yes, provide a description: This questionnaire and the loss information shown in the attached ACORD applications are understood to be an inducement to the issuance of a policy of insurance by company and the applicant warrants that all answers to questions are true and correct to the best of applicant's knowledge and belief. The undersigned authorizes the Company to obtain information necessary for evaluation in determining acceptability including but not limited to motor vehicle reports, credit reports and physical inspection. Insured Signature: Title:	b. List branch locations and number of employees:			
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