McKee Risk Management, Inc.	Employee Benefits Liability Questionnaire

I. APPLICANT INFORMATION

Named Insured: ____	Effective Date: ____

Names of Any Subsidiary Organizations:

1. 4.
2. 5.
3. 6.

Location Address	Street: ____	City: ____	State: ____	Zip: ____

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. QUESTIONNAIRE

1. 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? ____	☐ Yes ☐ No
3. Are employees required to review their benefit elections at least annually?	☐ Yes ☐ No
4. Does the Applicant have an EEOC policy?	☐ Yes ☐ No

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?	☐ Yes ☐ No

9. List the Benefits available to employees and indicate the approximate time when eligible:

Benefit	**When eligible**
____	____
____	____
____	____
____	____
____	____

10. When Benefits become available at a date subsequent to employment, what controls are established to assure that employee is again contacted?

11. Are employees who are leaving the company eligible for group health benefits under “COBRA” Law? ☐ Yes ☐ No

If Yes, what are the procedures for notifying the employee?

McKee Risk Management, Inc.	Employee Benefits Liability Questionnaire

III. QUESTIONNAIRE (Continued)

12. Employee Totals:	Number of Employees
a. Number of employees at main location:	
b. List branch locations and number of employees:	
Branch Location	
1.	
2.	
3.	
4.	
5.	
Total Number of Employees:	

13. Is any hiring of employees done in branch offices? ☐ Yes ☐ No

a. **If Yes**, by what means does the personnel department exercise control over the counseling of branch 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? ☐ Yes ☐ No

15. Does the operation involve any of the following:

a. Major Occupational Disease exposure? ☐ Yes ☐ No

b. Significant % of seasonal work? ☐ Yes ☐ No

c. High employee turnover? ☐ Yes ☐ No

16. Has Employee Benefits Coverage been carried in the past? ☐ Yes ☐ No

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: ☐ Yes ☐ No

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: _____

Date: _____

Agent Signature: _____

Title: _____

Date: _____