

# National Casualty Company

Home Office:  
 Scottsdale, Arizona 85258  
 Administrative Office:  
 8877 North Gainey Center Drive • Scottsdale, Arizona 85258  
 1-800-423-7675 • Fax (480) 483-6752

## APPLICATION PERSONNEL CONSULTANTS AND TEMPORARY HELP SERVICES

**EACH COVERAGE PART MAY BE OFFERED ON A CLAIMS MADE AND REPORTED BASIS.  
 PLEASE READ THESE COVERAGE PARTS CAREFULLY.**

<b>APPLICANT INFORMATION</b>
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1. Name of Applicant (please include DBAs): \_\_\_\_\_  
 ( Check if additional paper is used): \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Website Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Individual     Partnership     Corporation     LLC     Other: \_\_\_\_\_  
 Applicant is: Franchisor? .....  Yes  No  
                   Franchisee? .....  Yes  No
2. Date established: \_\_\_\_\_ (If less than two years, please attach resumes of all principals.)
3. Effective date requested: \_\_\_\_\_

Coverages	Limits Requested (check one per Coverage)	Deductible Requested (check one per Coverage)
PROFESSIONAL LIABILITY <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made Retroactive Date: _____	<input type="checkbox"/> \$250,000/\$500,000 <input type="checkbox"/> \$250,000/\$750,000 <input type="checkbox"/> \$500,000/\$500,000 <input type="checkbox"/> \$1,000,000/\$1,000,000 <input type="checkbox"/> \$1,000,000/\$2,000,000 <input type="checkbox"/> Other \$ _____/\$ _____	<input type="checkbox"/> None <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> Other \$ _____
EMPLOYMENT PRACTICES LIABILITY	<input type="checkbox"/> \$250,000/\$500,000 <input type="checkbox"/> \$250,000/\$750,000 <input type="checkbox"/> \$500,000/\$500,000 <input type="checkbox"/> \$1,000,000/\$1,000,000 <input type="checkbox"/> \$1,000,000/\$2,000,000 <input type="checkbox"/> Other \$ _____/\$ _____	<input type="checkbox"/> None <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> Other \$ _____
GENERAL LIABILITY (not available in NY, RI or WA)	<input type="checkbox"/> \$250,000/\$500,000 <input type="checkbox"/> \$250,000/\$750,000 <input type="checkbox"/> \$500,000/\$500,000 <input type="checkbox"/> \$1,000,000/\$1,000,000 <input type="checkbox"/> \$1,000,000/\$2,000,000 <input type="checkbox"/> Other \$ _____/\$ _____	<input type="checkbox"/> None <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> Other \$ _____

**CORPORATE OVERVIEW**

5. Provide the following financial information for the last two years:

<b>Current Year (Twelve [12] month numbers—estimate if necessary)</b>	<b>Previous Year (Twelve [12] month actual)</b>
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____

Total annual gross revenues (revenues before expenses):

Total annual gross revenues derived from permanent placement:

Total annual gross revenues derived from temporary help placement:

Total annual gross revenue derived from other services:

Identify "other" services: \_\_\_\_\_

6. Does Applicant have positive net worth? .....  Yes  No

7. Does Applicant have sufficient working capital? .....  Yes  No

**PAYROLL AND PLACEMENTS**

8. Principal industries served by the Applicant for Temporary Placements: \_\_\_\_\_

9. Principal industries served by the Applicant for Permanent Placements: \_\_\_\_\_

10. Number of average annual placements:

Permanent: .....

Temporary: .....

11. Total amount of annual temporary placement payroll: ..... \$ \_\_\_\_\_

12. If a payroll amount was indicated in question 11. above, please provide the percentage by placement type:

If  "N/A," skip to question 13. Percentages should be projections for the next twelve (12) months and total must equal one hundred percent (100%).

<b>Placement Type</b>		<b>Percentage</b>
A	Clerical/Secretarial	%
B	Industrial Staff, Construction, Temporary Drivers*	%
C	Bank Tellers, Bookkeepers, Call Center, Data Entry, Facilities/Property Management, Hospitality, HR, Mortgage Broker, Paralegals, Real Estate Agent, Sales Personnel, Telemarketer, Management Consulting	%
D	Accountants*, Actuaries*, Auditors, Collections, Customer Service, Insurance Adjusters, Investment Brokers or Advisor (no check drafting or auditor opinions), Lawyers*	%
E	IT, EDP Software Engineer*, EDP Programmer*	%
F	Architect*, Draftsman*, Civil Engineer*, Electrical Engineer*, Mechanical Engineer*, Medical*	%
Other (Describe): _____		%

\* Coverage restrictions may apply based on eligibility.

If Architect or Engineer Temporary Placements are made, do they have sign-off authority on any project including blueprints? .....  Yes  No  N/A

Are written client services contracts used for Professional Placements? .....  Yes  No  N/A

If "Yes," do they contain a Hold Harmless Clause? .....  Yes  No

If "Yes," do they contain a Direction and Control of Client Clause?.....  Yes  No

If "No," to either of the above, does the Applicant agree to implement a contract using Hold Harmless and/or a Direction and Control clauses within ninety (90) days? .....  Yes  No  N/A

13. By state, please list the total number of locations and employees (including owners and employees of subsidiaries for which coverage is desired) for the current year ( Check if additional paper used):

STATE (in which offices are located)								
Number of Locations								
Number of Professionals/Placers involved in recruiting (including owners)								
All other employees/independent contractors in Applicant's office								
Temporary employees/independent contractors Applicant place with clients								

14. Has Applicant's staff increased or decreased fifteen percent (15%) or more in the past year? .....  Yes  No  
 If "Yes," please explain: \_\_\_\_\_

15. Percentage of employees by salary range (each column should total one hundred percent [100%]):

Range	All Employees	Permanent Placements	Temporary Employees
Less than \$30,000	%	%	%
\$30,000 to \$50,000	%	%	%
\$50,001 to \$100,000	%	%	%
\$100,001 to \$200,000	%	%	%
Over \$200,000	%	%	%

16. Does the Applicant conduct background checks?.....  Yes  No  
 If "Yes":

- a. On what percentage of candidates does the Applicant perform background checks?..... \_\_\_\_\_ %  
 b. Does the Applicant subcontract this activity out to others? .....  Yes  No  
 c. Are all background checks conducted in compliance with the Criminal Offender Record Information (CORI) reform law? (Applicable in Massachusetts only) .....  Yes  No

17. Does the Applicant have a written procedural manual for employees to follow? .....  Yes  No

18. Please provide information regarding coverage currently in force:

	Insurance Company	Expiration Date	Coverage Limits	Deductible	Premium
Professional Liability				\$	\$
Employment Practices Liability				\$	\$
General Liability				\$	\$

Professional Liability currently in forms is: .....  Claims Made  Occurrence  
 If Claims Made, Retroactive Date/Prior Acts Date: ..... \_\_\_\_\_  
 Attach Declarations from current policy.

**EMPLOYMENT PRACTICES LIABILITY COVERAGE**

19. Is Employment Practices Liability (EPLI) coverage desired? .....  Yes  No  
 If "No," skip to question 31.

20. Does Applicant have an employee handbook or manual? .....  Yes  No
21. Does Applicant have an individual trained to handle personnel/human resource functions? .....  Yes  No
- If questions 20. and/or 21. are answered "No" and the Applicant has fifty (50) or more employees (including temporary workers), the Applicant will be required to implement these within ninety (90) days of the effective date of any policy that may be issued. Will you agree to implement these within ninety (90) days? .....  Yes  No
22. Does Applicant provide a sexual harassment statement to employees as follows:
- a. Statement clearly states who an incident should be reported to (including an alternate if needed)?.....  Yes  No
- b. Statement advising them that they need to advise management if they are being harassed in any fashion? .....  Yes  No
- c. Statement is signed by the employee? .....  Yes  No
23. Does Applicant provide an EEOC statement to employees which is signed by the employee?.....  Yes  No
24. Does Applicant provide an At Will statement to employees? .....  Yes  No
25. Are all equal opportunity notices posted in common areas? .....  Yes  No
26. Does Applicant have procedures to comply with the American Disabilities Act? .....  Yes  No
27. Does Applicant use a formal, standardized employment application with an EEOC statement? .....  Yes  No
28. Does Applicant maintain written records of all performance reviews and disciplinary actions? .....  Yes  No
29. Does Applicant have a written procedure in place that explains to management what procedures should be followed if a Temporary Placement Worker notifies the Applicant that he or she has been harassed? .....  Yes  No  N/A
- If any of questions 22. through 29. are answered "No" and the Applicant has ten (10) or more employees (including temporary workers), the Applicant will be required to implement procedures to comply with the appropriate Employment Practices within ninety (90) days of the effective date of any policy that may be issued. Will you agree to implement the required procedures within ninety (90) days? .....  Yes  No  N/A
30. If a written policy is not already in place that states that employees should not harass or discriminate against non-employees, will the Applicant agree to implement one within one hundred eighty (180) days? .  Yes  No  N/A (written policy is in place)

**GENERAL LIABILITY COVERAGE (Not Available in NY, RI or WA)**

31. Is General Liability coverage desired? .....  Yes  No
- If "No," skip to question 45.

32. Complete the following for any owned or leased premises:

Location Address	Occupancy	Square Footage	Age of Building	Updated in Past Five Years
	<input type="checkbox"/> Owned <input type="checkbox"/> Leased			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Owned <input type="checkbox"/> Leased			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Owned <input type="checkbox"/> Leased			<input type="checkbox"/> Yes <input type="checkbox"/> No

33. Is prior related experience required of employees? .....  Yes  No
34. Are formal classroom training programs in operation? .....  Yes  No
35. Is an on-the-job training program established? .....  Yes  No
36. Is a formal safety program in operation? .....  Yes  No

37. Are medical facilities located on premises? .....  Yes  No

38. Are medical facilities accessible within ten (10) minutes?.....  Yes  No

**ADDITIONAL GENERAL LIABILITY COVERAGES**

39. Check additional general liability coverages desired:

a.  Employee Benefits Liability Coverage (Claims Made) Limit desired? ..... \$ \_\_\_\_\_  
 (same as GL or less)

If requested, does Applicant currently carry Employee Benefits Liability Coverage? .....  Yes  No

If "Yes," what is the Retroactive Date: ..... \_\_\_\_\_

b.  Hired & Nonowned Automobile Limits desired? ..... \$ \_\_\_\_\_  
 (same as GL or less/maximum of \$1,000,000)

If requested, please complete the Hired & Nonowned Automobile Supplement.

c.  Personal Property of Others In Your Care, Custody or Control

d.  Increase in Medical Payments to \$10,000 from \$5,000

e.  Additional Insureds (if checked, complete question 40. below)

f.  Waiver of transfer of rights of recovery (if checked, complete question 41. below)

g.  Employers Liability/Stop Gap Coverage (applicable in ND, OH or WA only)

If requested, please indicate Total Company Payroll: ..... \$ \_\_\_\_\_

Employers Liability/Stop Gap GL Limit desired:

\$250,000 Bodily Injury by Accident—**Each Accident**/\$250,000 Bodily Injury by Disease—**Each Employee**/\$500,000 Aggregate

\$500,000 Bodily Injury by Accident—**Each Accident**/\$500,000 Bodily Injury by Disease—**Each Employee**/\$500,000 Aggregate

\$1,000,000 Bodily Injury by Accident—**Each Accident**/\$1,000,000 Bodily Injury by Disease—**Each Employee**/\$1,000,000 Aggregate

40. Are you required to name any other business or person as an additional insured? .....  Yes  No

If "Yes," please list name and address of each and state interest. Use separate sheet if required.

Name	Address	Interest

41. Are you required to waive your subrogation right against another business or person? .....  Yes  No

If "Yes," please list name and address of each and state interest. Use separate sheet if required.

Name	Address	Interest

42. Does the Applicant place employee(s) in a position which requires the employee(s) to operate:

- |  |   |
|--|---|
| <input type="checkbox"/> Forklifts                                       | <input type="checkbox"/> Earth moving equipment (bulldozers, graders, etc.) |
| <input type="checkbox"/> Fixed machinery at site                         | <input type="checkbox"/> Cranes   |
| <input type="checkbox"/> Mobile equipment (floor sweepers, mowers, etc.) | <input type="checkbox"/> Aircraft or watercraft                             |

43. Does the Applicant require temporary employees to be OSHA certified in equipment operation prior to placement? .....  Yes  No  
 If "No," explain: \_\_\_\_\_

44. Does Applicant require an agreement from the client which holds Applicant harmless for any responsibility for claims resulting from the operation of the above-mentioned equipment referred to in question 42.?  Yes  No

**CLAIMS**

45. In the last five years, have there been claims, incidents or regulatory complaints made against any employee or former employee, the Applicant or anyone proposed for this insurance:

Professional Liability	Employment Practices	General Liability	Other Coverages
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- a. Is the Applicant or anyone proposed for this insurance aware of any circumstances which might give rise to a Professional Liability or EPLI claim, incident or regulatory complaint?.....  Yes  No  
 If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.
- b. Is the Applicant or anyone proposed for this insurance aware of any charges, inquiries, investigations, grievances or other administrative hearings in the last five years or currently? .....  Yes  No  
 If "Yes," to any, please complete a Claim/Circumstance/Administrative Hearings Supplement for each.
- c. During the last five years, has the Applicant or anyone proposed for this insurance been the subject of claims by a non-employee for discrimination or harassment?.....  Yes  No
- d. Has prior Professional Liability and/or EPLI coverage ever cancelled or non-renewed (other than being non-renewed due to the carrier no longer writing these coverages)? (Not applicable to Missouri Applicants.).....  Yes  No  
 If "Yes," please explain: \_\_\_\_\_

**FRAUD WARNINGS AND SIGNATURE SECTION**

**NOTE: THE APPLICANT UNDERSTANDS AND AGREES THAT IF ANY FACTS, INCIDENTS OR CIRCUMSTANCES EXIST WHICH MAY REASONABLY GIVE RISE TO A CLAIM UNDER THIS PROPOSED POLICY, THEN ANY CLAIMS ARISING FROM SUCH FACTS, INCIDENTS OR CIRCUMSTANCES ARE EXCLUDED FROM COVERAGE.**

**SIGNATURE SECTION AND OTHER INFORMATION**

**NOTE:** Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

**THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.**

**THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS PRIOR TO BINDING THE INSURANCE.**

**THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.**

**THE APPLICANT UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY BE ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY.**

**THE APPLICANT ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION OR OTHERWISE.**

**THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THE REPRESENTATION, ON BEHALF OF THE APPLICANT OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.**

**FRAUD WARNING:** 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 such person to criminal and civil penalties. (Not applicable in AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT or WA.)

**NOTICE TO ALABAMA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**NOTICE TO COLORADO APPLICANTS:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**WARNING TO DISTRICT OF COLUMBIA APPLICANTS:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE TO FLORIDA APPLICANTS:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**NOTICE TO KANSAS APPLICANTS:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**NOTICE TO LOUISIANA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO MAINE APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NOTICE TO MARYLAND APPLICANTS:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO MINNESOTA APPLICANTS:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he 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.

