Steve Nurre 10-99 mma In NAble

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|  | | | | | | | **Church Mutual Insurance Company**  **3000 Schuster Lane, P.O. Box 357**  **Merrill, Wisconsin 54452** | | | | | | | | | |  | |
| **APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY COVERAGE** | | | | | | | | | | | | | | | | | | |
| **THIS IS AN APPLICATION FOR CLAIMS‑MADE COVERAGE.** | | | | | | | | | | | | | | | | | | |
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|  | (Name of Organization) | | | | | | | | | | | | | | | | |  |
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|  | (Address) | | | | | | | | | | | | | | | | |  |
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|  | (City) | | | | | | | | | | (State) | | | | (Zip Code) | | |  |
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| (If you need additional space for any answer, please continue in the Remarks Section.) | | | | | | | | | | | | | | | | | | |
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| 1. | | | Provide a brief description of applicant's operations: | | | | | | | | | | | | | | | |
|  | | | House of Worship | | | | | | | | | | | College/Seminary | | | | |
|  | | | Denominational Office | | | | | | | | | | | Camp | | | | |
|  | | | Health Care Facility/Nursing Home | | | | | | | | | | | Day Care/School | | | | |
|  | | | Other (Explain) | | | | | | |  | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | |
| 2. | | | Is the Organization incorporated?  Yes  No If no, what is the legal status of the | | | | | | | | | | | | | | | |
|  | | | Organization: | | | | |  | | | | | | | | | | |
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|  | | | (a) | | Date of incorporation: | | | | | | |  | | | | | | |
|  | | | (b) | | Any subsidiaries?  Yes  No If yes, please explain: | | | | | | | | | | |  | | |
|  | |  | | | |  | | | | | | | | | | | | |
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|  | | | (c) | | Is applicant a subsidiary of another organization?  Yes  No If yes, please | | | | | | | | | | | | | |
|  | |  | | | explain: | | | |  | | | | | | | | | |
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| 3. | | | Within the scope of this proposed insurance: | | | | | | | | | | | | | | | |
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|  | | | (a) | | Have there been any claims or lawsuits made, or are any now pending against the organization, or any person who may be covered by this insurance? If yes, please provide | | | | | | | | | | | | | |
|  | | |  | | details. If no, state "NONE": | | | | | | | |  | | | | | |
|  | | |  | | |  | | | | | | | | | | | | |
|  | | | (b) | | Does any person who may be covered by this insurance have any knowledge or information of any breach of duty, error, misstatement, misleading statement, or omission which could give rise to a claim against them? If yes, please provide details. If no, state "NONE": | | | | | | | | | | | | | |
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| 4. | | | Has the organization or anyone associated with the organization been involved in or have any knowledge of pending federal, state, or local action or proceedings against the organization or anyone associated with the organization? If yes, please provide details. If no, state "NONE": | | | | | | | | | | | | | | | |
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| 5. | | Number of paid employees/staff: | | | | | | Full‑time | |  | | | | | Part‑time | | |  | |  | |
|  | | How many have been terminated in the last three years? | | | | | | | | | | |  | | | |  | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | |
|  | | Breakdown of Employees | | | | | | | # of Employees | | | Breakdown of Employees | | | | | | | # of Employees | | |
|  | |  | House of Worship | | | | | |  | | |  | | Day Care/School | | | | |  | |
|  | |  | Denominational Office | | | | | |  | | |  | | College/Seminary | | | | |  | |
|  | |  | Health Care Facility/Nursing Home | | | | | |  | | |  | | Camp | | | | |  | |
|  | |  | Other | | | | | |  | | |  | |  | | | | |  | |
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| 6. | | Please indicate below which written employment policies and procedures are in place (provide any additional applicable information in Remarks Section below): | | | | | | | | | | | | | | | | | | | |
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|  | |  | Hiring of Employees | | | | | | | | | | | | | | | | | | |
|  | |  | Disciplining Employees | | | | | | | | | | | | | | | | | | |
|  | |  | Employment Termination | | | | | | | | | | | | | | | | | | |
|  | |  | Does your organization seek counsel from an attorney prior to terminating or laying off employee(s)?  Yes  No | | | | | | | | | | | | | | | | | | |
|  | |  | Sexual Harassment Prevention | | | | | | | | | | | | | | | | | | |
|  | |  | Anti-discrimination Plans | | | | | | | | | | | | | | | | | | |
|  | |  | Compliance with Federal Employment Acts (e.g., ADA, FMLA) | | | | | | | | | | | | | | | | | | |
|  | |  | Investigation and Handling of Employment-Related Grievances | | | | | | | | | | | | | | | | | | |
|  | |  | Performance Evaluations | | | | | | | | | | | | | | | | | | |
|  | |  | Job Descriptions | | | | | | | | | | | | | | | | | | |
|  | |  | Employee Handbook | | | | | | | | | | | | | | | | | | |
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| 7. | | Does the organization use an employment application which includes an employment at will statement?  Yes  No | | | | | | | | | | | | | | | | | | | |
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| 8. | | Has the organization previously applied for EPL coverage with any insurance company?  Yes  No | | | | | | | | | | | | | | | | | | | |
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| 9. | | List any EPL insurance carried during the last six years: | | | | | | | | | | | | | | | | | | | |
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|  | | Insurer: | | |  | | | | | | | | | | | | | | | | |
|  | | Limit of Insurance: | | | | |  | | | | Retention: | | | | |  | | | | | |
|  | | Premium: | | | |  | | | | Expiration Date: | | | | | |  | | | | | |
|  | | Retroactive Date: | | | | |  | | | Claims‑Made  Occurrence | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | |
|  | | Insurer: | | |  | | | | | | | | | | | | | | | | |
|  | | Limit of Insurance: | | | | |  | | | | Retention: | | | | |  | | | | | |
|  | | Premium: | | | |  | | | | Expiration Date: | | | | | |  | | | | | |
|  | | Retroactive Date: | | | | |  | | | Claims‑Made  Occurrence | | | | | | | | | | | |
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| Remarks: | | | |  | | | | | | | | | | | | | | | | | |
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| **WARRANTY:** | | | | |
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| The undersigned Officer of the Organization declares the statements set forth herein are true. The undersigned Officer agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, the undersigned will immediately notify the company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.  Although the signing of this application does not bind the undersigned on behalf of the Organization to effect this Insurance, the undersigned on behalf of the Organization agrees that this application and the said statements shall be the basis of any insurance contract or agreement which may be made. The Insurer is hereby authorized to make any investigation and inquiry in connection with this application.  It is agreed that any claim or action arising out of any wrongful act, wrongful employment practice, error, or omission which is known to any person proposed for this insurance prior to the issuance of the policy and not disclosed in this application is excluded from coverage.  Application or signing of the application does not bind coverage or require the company or agent to provide insurance. However, it is agreed that this application shall be the basis of the contract should a policy be issued and this application shall be considered part of the contract.  An offer to provide coverage may include terms and conditions which are materially different from your previous coverage. The Company shall not be obligated to provide terms in accordance with previously provided coverage or currently requested coverage and terms and conditions may be offered which are materially different from those requested. | | | | |
| IF A POLICY IS ISSUED, THIS APPLICATION WILL BE RETAINED ON FILE BY CHURCH MUTUAL AND FORM A PART OF THE POLICY. | | | | |
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| Signed | |  | |  |
|  | | Chairperson, President, or Other Authorized Signature | |  |
| Title |  | | |  |
|  | |  | |  |
| Date of Signature | | |  |  |
|  | | |  |  |