



Name of Insurance Company to which application is made

**APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE
FLORIDA**

NOTICE: THIS IS A PROPOSAL FOR A CLAIMS-MADE AND REPORTED POLICY. THE POLICY FOR WHICH THIS PROPOSAL IS MADE IS LIMITED TO LIABILITY FOR WRONGFUL ACTS FOR WHICH CLAIMS ARE FIRST MADE WHILE THE POLICY IS IN FORCE AND WHICH ARE REPORTED TO THE INSURER NO LATER THAN SIXTY (60) DAYS AFTER THE TERMINATION OF THE POLICY.

THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSS, INCLUDING JUDGEMENT OR SETTLEMENT AMOUNTS, SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE AND OTHER CLAIM EXPENSES. FURTHER NOTE THAT AMOUNTS INCURRED FOR LEGAL DEFENSE AND OTHER CLAIM EXPENSES SHALL BE APPLIED AGAINST THE APPLICABLE RETENTION AMOUNT.

THE POLICY DOES NOT PROVIDE FOR ANY DUTY OR OBLIGATION ON THE PART OF THE INSURER TO DEFEND THE INSURED PERSONS AND THE COMPANY.

Instructions:

- A. Answer all questions. If the answer to any question is NONE, please state NONE.
 - B. If the space to answer any question fully is insufficient, attach a separate sheet.
 - C. The application must be signed and dated by the owner, partner, or officer and by a human resources or personnel officer.
 - D. **PLEASE READ CAREFULLY THE STATEMENT AT THE END OF THIS APPLICATION.**
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GENERAL INFORMATION

1. Applicant's name and address:
(Please include the names of all companies and subsidiaries which are to be covered if the policy is issued.)

2. Name, title, and phone number of person to contact:

3. Describe the applicant's operations and give the number of locations by state:

4. Coverage desired:

Limit of Liability: _____

Proposed Effective Date: _____

Deductible: _____

Retroactive Date: _____

5. Do you currently carry Employment Practices Liability Insurance?

Yes No

If yes, please provide details as to the Insurer, the limits of liability, deductibles, retroactive date and premium.

6. Do you currently carry Directors and Officers liability insurance?

Yes No

If yes, please provide the name of the carrier and also indicate the limits of liability?

7. Employees:

a. Please provide the number of full-time and part-time employees in the following geographical locations:

	full-time	part-time
California and / or Texas	_____	_____
Michigan, Montana, Missouri, Ohio, and / or New Jersey	_____	_____
All other states	_____	_____
Total	_____	_____

b. Indicate below by their salary ranges the number of employees:

Salary ranges	full-time	part-time
\$ 30,000 or less per year	_____	_____
\$ 30,001 - \$ 50,000 per year	_____	_____
\$ 50,001 - \$100,000 per year	_____	_____
Over \$100,000 per year	_____	_____
Total	_____	_____

c. For each of the last four (4) years, state your annual percentage turnover rate of employees.

_____ % _____ % _____ % _____ %

d. For each of the last four (4) years, indicate the number of officers and other employees that have been involuntarily terminated.

_____ _____ _____ _____

e. Do any employees have written contracts of employment?

Yes No

If yes, how many? _____ Please attach a specimen contract.

LOSS HISTORY

8. a. Regardless of whether or not such loss may have been covered by any insurance policy, have you had or do you presently have any employment related claims including, but not limited to, complaints, charges, grievances, arbitrations, litigation, or administrative agency proceeding (federal, state, or local) concerning employment termination, discrimination, sexual harassment, wage and hour violations, and unfair labor practices?

Yes No If yes, for each of the past five (5) years, please provide the following information:

Year	Number of Claims	Damage or Settlement Amount	Legal Expense Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

b. Have you ever been involved in any claim or proceeding of the type described in a. above, for which you or your insurer has paid or reserved in excess of \$ 10,000 (including amounts paid or reserved for the defense of the claim or proceeding)? Yes No

If yes, please complete and attach the **EMPLOYMENT PRACTICES LIABILITY APPLICATION CLAIM SUPPLEMENT** for each such claim or proceeding. If there were no claims or proceedings paid or reserved in excess of \$ 10,000 state NONE. _____

c. Are you aware of actual or alleged wrongful employment practices or other facts incidents, or circumstances that may result in claims being made against you? For purposes of this question, wrongful employment practices include employment terminations, constructive discharge from employment, discrimination for whatever reason, and sexual harassment.

Yes No

If yes, please explain on a separate sheet.

IT IS UNDERSTOOD AND AGREED THAT AS TO ANY WRONGFUL EMPLOYMENT PRACTICE CLAIM, WRONGFUL EMPLOYMENT PRACTICE, FACT, INCIDENT, OR CIRCUMSTANCE THAT ARE OR SHOULD BE DISCLOSED IN RESPONSE TO QUESTIONS 8. a., b., OR c. ABOVE, ANY CLAIM ARISING THEREFORM IS EXCLUDED FROM COVERAGE UNDER THE POLICY FOR WHICH THIS APPLICATION IS MADE.

HUMAN RESOURCES DEPARTMENT

9. a. Do you have a Human Resources or Personnel Department? Yes No
How many employees are in this department? _____

If no, please provide details on the handling of this function on a separate page.

b. Do you have a formal out-placement program which assists terminated or laid-off employees in finding other jobs? Yes No

If yes, please describe the program. _____

c. Provide the name and address of any firm performing employee review, disciplinary, or employee hiring services, and furnish a description of the services provided.

d. Do you use a written employment application form for your employment applicants? Yes No

e. Do you make use of tests to screen employment applicants? Yes No

If yes, please provide details.

- f. Do you have an employment handbook? Yes No
 If yes, is the handbook distributed to all of your employees? Yes No
- g. Do you have a formal orientation program for all new employees? Yes No
 If yes, please provide details.
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- h. Do you conduct regular written performance evaluations of all your employees? Yes No
- i. Do you have an affirmative action plan? Yes No
 If yes, please provide a copy.
- k. Do you have formal policies or procedures regarding:
- 1) sexual harassment? Yes No
 - 2) the handling of employee complaints of discrimination or sexual harassment? Yes No
 - 3) AIDS or assisting employees with life threatening or communicable diseases? Yes No
 - 4) accommodating the disabled in accordance with the Americans With Disabilities Act? Yes No
 - 5) the Family and Medical Leave Act of 1993? Yes No

If you answered yes to any of the items in this question 9., please provide copies of all such policies, forms, and handbooks together with information regarding the distribution of such policies, forms, and handbooks to your employees, e.g. notices on bulletin boards, annual distribution to all employees, etc.

10. Do you require that all employment terminations be reviewed prior to discharge by:
- 1) the Human Resources Department? Yes No
 - 2) the Legal Department? Yes No
 - 3) outside counsel? Yes No
-

11. Do you anticipate any full or partial plant, facility, branch, or office closing or layoffs within the next twenty-four (24) months? Yes No
 If yes, please provide details on a separate page(s).
-

12. Do you anticipate any lay-offs or reduction in force (RIF) within the next twenty-four (24) months? Yes No
 If yes, please provide details on a separate page(s).
-

13. Do you have written procedures for disciplining employees? Yes No
-

14. Do you have written procedures for terminating employees? Yes No
-

CORPORATE HISTORY

15. a. Has your business name changed? Yes No
 If yes, list all former names on a separate sheet.
- b. 1) Have you acquired any new subsidiaries or other business organizations in the last five (5) years? Yes No
 - 2) If yes, did the purchase include the assumption of liabilities? Yes No
 - 3) If yes, does the information provided in response to Question 8. include these Yes No

acquired subsidiaries or organizations?

- 4) With respect to acquired subsidiaries or organizations, were any employees or officers terminated or do you plan in the next eighteen (18) months to terminate any employees or officers? Yes No
- c. 1) Have you sold any subsidiaries or other business organizations in the last five (5) years? Yes No
- 2) Did the sale include the transfer of liabilities to the purchaser? Yes No

CLAIMS HANDLING PROCEDURES

16. a. Who in the insured's organization will be responsible for the reporting of claims to the insurer under any policy that may be issued pursuant to this application?

Name: _____ Title: _____

Address: _____

Telephone Number (include area code): _____

- b. Who in the insured's organization will be responsible for handling claims in conjunction with the insurer under any policy that may be issued pursuant to this application?

Name: _____ Title: _____

Address: _____

Telephone Number (include area code): _____

- c. With respect to claims, incidents, etc.:

- 1) Do you have a written procedure for obtaining information: Yes No
If yes, please provide a copy.
- 2) Have you made supervisory personnel aware in writing of your desire for prompt notice? Yes No
If yes, please provide a copy.

THIS APPLICATION WILL ONLY BE PROCESSED IF THE FOLLOWING APPLICABLE INFORMATION IS INCLUDED. FAILURE TO INCLUDE THE APPLICABLE INFORMATION FOR ANY COMPANY TO BE COVERED BY THIS INSURANCE WILL DELAY THE ISSUANCE OF A QUOTE UNTIL THE INFORMATION IS RECEIVED OR WILL RESULT IN A QUOTE EXCLUDING THE COMPANY(IES) FOR WHICH THE INFORMATION HAS NOT BEEN RECEIVED.

Indicate attachments by an (X):

- | | |
|---|--|
| a. <input type="checkbox"/> Financial Statements | e. <input type="checkbox"/> Employment Application Form(s) |
| b. <input type="checkbox"/> Securities and Exchange Commission Form 10-K | f. <input type="checkbox"/> Supervisory Manual(s) |
| c. <input type="checkbox"/> Employee Handbook, manual, and work rules | g. <input type="checkbox"/> Employee Performance Form(s) |
| d. <input type="checkbox"/> Employee disciplinary, termination and out-placement procedures | h. <input type="checkbox"/> EEO-1 Report |

THE UNDERSIGNED AUTHORIZED APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE. THE "EFFECTIVE DATE" IS THE DATE THE COVERAGE IS BOUND OR THE FIRST DAY OF THE CURRENT POLICY PERIOD, WHICHEVER IS LATER.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

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.

NOTE: BOTH SIGNATURE LINES MUST BE COMPLETED.

_____	_____	_____
Date	Applicant's Authorized Signature of a Principal, Partner, or Officer	Title

Please Print Name

_____	_____	_____
Date	Applicant's Authorized Signature of individual in charge of the Human Resources or Personnel Department	Title

Please Print Name

Agent Name

Agent License Number

PLEASE SUBMIT THIS PROPOSAL AND APPROPRIATE MATERIALS TO:

Hartford Financial Products
2 Park Avenue
New York, N.Y. 10016

APPLICATION FOR EMPLOYMENT PRACTICES LIABILITY INSURANCE

SUPPLEMENTAL CLAIM FORM

This form is to be completed by each applicant who has been involved in any claim or suit or who is aware of any incident which may give rise to a claim. Please complete a separate sheet for each claim or incident and answer all questions fully. A principal of the firm must sign and date this sheet in addition to the application.

1) NAME OF FIRM: _____

2) NAME OF INDIVIDUALS OF FIRM INVOLVED IN CLAIMS: _____

3) NAME OF CLAIMANT (PLAINTIFF): _____

4) DATE OF ALLEGED ERROR: _____

5) DATE CLAIM MADE: _____

6) NAME OF INSURER CLAIM REPORTED TO (IF APPLICABLE): _____

7) PRESENT STATUS OF CLAIMS: PENDING CLOSED IN SUIT

8) IF CLOSED, TOTAL DAMAGES PAID: _____ TOTAL EXPENSES PAID: _____

9) IF PENDING, AMOUNT ASKED IN SUMMONS: _____

CLAIMANT'S SETTLEMENT DEMAND: _____

DEFENDANT'S SETTLEMENT OFFER: _____

INSURER'S LOSS RESERVE: _____

EXPENSES PAID TO DATE: _____

10) DETAILED DESCRIPTION OF CLAIM AND EVENTS: (PROVIDE CLAIMANT'S ALLEGATIONS AND OUR FIRM'S RESPONSE)

11) EXPLAIN WHAT ACTIONS HAVE BEEN TAKEN TO PREVENT A RECURRENCE OR SIMILAR CLAIM:

I UNDERSTAND THE INFORMATION SUBMITTED HEREIN BECOMES A PART OF MY EMPLOYMENT PRACTICES LIABILITY INSURANCE APPLICATION AND IS SUBJECT TO THE SAME ONDITIONS.

APPLICANT'S SIGNATURE

DATE



**SUPPLEMENT I: THIRD PARTY CLAIM QUESTIONNAIRE
FLORIDA**

1. Does the **Insured's** current Employment Practices Liability Policy provide Third Party Insurance? Yes No
Limit: _____ Retention: _____ Pending and Prior Litigation Date: _____
2. Does the **Insured** have a written policy prohibiting all forms of harassment, discrimination, and civil rights violations committed against customers, clients, vendors and/or other third parties? Yes No
3. Does the **Insured** have established written procedures for handling third party complaints of harassment, discrimination, and civil rights violations? (If yes, attach a copy of these written procedures.) Yes No
4. (a) Does the **Insured** conduct training on third party discrimination, harassment (including sexual) and civil rights violation prevention? Yes No
(b) Who is required to attend this training? _____
(c) Who conducts the training? _____
(d) How often is training conducted? _____
(If necessary, please attach a separate sheet.)
5. (a) During the past five years has the **Insured** ever had a claim, circumstance or incident brought against them by a customer, client, vendor and/or third party? Yes No
(b) If yes, please attach a list of all such matters. Include a description of the allegations, name of the plaintiff(s), name of the defendant(s), the defense counsel, court involved, current status, defense costs, indemnity costs and reserves.
(c) If yes, what steps has the **Insured** taken to eliminate or mitigate the chances of a similar problem in the future?

6. Approximately what percentage of the **Insured's Employees** is in contact with customers, clients, vendors and/or other third parties? _____%
7. Do any of the Applicant's **Employees** work at customer, client, vendor or other third party locations? Yes No
8. (a) Do **Employees** of any third party (i.e. security guards, etc.) perform services at your facilities? Yes No
(b) If yes, are they provided with a copy of the **Insureds** written policies and procedures as outlined in questions 1 and 2 above? Yes No
9. (a) Does the **Insured** have contractual agreements with third parties that perform services at their facilities? Yes No
(b) Are the agreements in writing? Yes No
(c) Does it include a written agreement to hold the **Insured** harmless and/or indemnify the **Insured** for wrongful actions by such third parties? Yes No
10. (a) Does the **Insured** extend credit to any customer, client or other third party? Yes No
(b) If yes, is it done internally or is it outsourced? _____

(c) If it is outsourced, does the **Insured** require the vendor to follow the written policies and procedures as outlined in questions 1 and 2 above? Yes No

11. (a) Does the **Insured** have any franchise operations, leased workers or independent contractors? Yes No

(b) If yes, does the **Insured** require them to follow the policies and procedures as outlined in questions 1 and 2 above? Yes No

12. Are any of the **Insured's Employees** compensated by commission? Yes No

If yes, please include job descriptions and the percentage of staff that work on commission:

13. (a) Are all of the **Insured's** locations in compliance with the American with Disabilities Act? Yes No

(b) Are all the **Insured's** entrances, exits and restrooms accessible to the disable, and in compliance with the American with Disabilities Act? Yes No

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Agent Name

Agent License Number

Applicant's Signature

Date



**SUPPLEMENT II: FOREIGN OPERATIONS EXPOSURE QUESTIONNAIRE
FLORIDA**

(Complete this section should coverage be requested for Foreign Operations Exposure)

1. Foreign Exposure (attach a separate form if necessary)

Country	Nature of Operations	Relationship to Parent Company (*see chart below)	Total Number of Employees	Total Number of Full-Time Employees	Total Number of Part-Time Employees

***Relationship to Parent Company**

- A = **Subsidiary**
- B = Affiliate
- C = Joint Venture
- D = Other – please describe

2. Loss History

(a) Please provide complete employment-related **Claim** and circumstance information for the past five (5) years. The list should include for each complaint, litigation or proceeding: (i) the type of allegation(s), (ii) the country, court and agency involved, (iii) description of any decision, determination or judgment rendered, (iv) total defense costs incurred to date in the litigation or proceeding, (v) any judgment or settlement amount and (vi) whether the litigation or proceeding remains pending or is closed.

(b) Describe how a non-U.S. employment **Claim** will be investigated and managed:

(If necessary, attach a separate form) _____

(c) Who is responsible for handling of non-U.S. **Claims**?

Name: _____ Title: _____

Location: _____

3. Employment Practices

(a) Do the foreign operations utilize the same employment policies and procedures as the U.S. operations?

- Yes
 No (If no, describe and attach any policies or procedures that are unique to the foreign operations.)

(b) Is there a director of human resources for non-U.S. operations?

- Yes (If yes, who does he/she report to?) _____
 No (If no, how does the **Insured** insure that all employment policies and procedures are enforced?) _____

- (c) Please provide an organizational chart which depicts where the non-U.S. Human Resources function exists.
- (d) Have all the non-U.S. operations handbooks, employment contracts, employment applications, employment and labor policies and procedures been reviewed by outside counsel familiar with local and foreign employment/labor law, rules, and regulations?
 Yes (If yes, when were they last reviewed and updated?) _____
 No

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Agent Name

Agent License Number

Applicant's Signature

Date



**SUPPLEMENTAL CLAIM FORM
FLORIDA**

This form is to be completed by each applicant who has been involved in any claim or suit or who is aware of any incident that may give rise to a claim. Please complete a separate sheet for each claim or incident and answer all questions fully.

1. The date the **Claim** was made: _____
2. The name of defendant (s): _____
3. The name of complainant (s): _____
4. Insurance carrier(s) in which the **Claim** was reported: _____
5. Type of **Claim**: Demand Letter – Attorney ____ Demand Letter – Complainant ____ Lawsuit ____ EEOC ____
Other Administrative Agency ____
6. Status of the **Claim**: Pending ____ Closed ____

If closed:

- What were the total damages paid? \$ _____
- What were the total expenses paid? \$ _____
- What was the date closed? _____

If pending:

- Is there a settlement demand? Yes ____ No ____
- What is the complainant's demand amount? \$ _____
- What are the total expenses paid to date? \$ _____
- What are the anticipated costs (defense and expense)? \$ _____

7. Please provide a detailed description of the **Claim**. Include allegations and the Insured's response to the allegations:

8. What steps have been taken to prevent and/or mitigate a recurrence or similar **Claim** in the future?

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Agent Name

Agent License Number

Applicant's Signature

Date

**SUPPLEMENT III - REDUCTION IN WORKFORCE QUESTIONNAIRE
FLORIDA**

(Complete this section if the Policyholder in the past 36 months completed or agreed to, or contemplates within the next 18 months any plant, facility, branch or office closing, consolidation or layoff)

1. Please provide the following workforce details: (Please provide a separate sheet if necessary)

Date of reduction in workforce	Reason for reduction in workforce	Number of Employees affected by the reduction

2. Did or will the reduction in workforce comply with the Worker Adjustment and Retraining Notification Act (WARN)? Yes No

3. Who will make or who made the decision to reduce the workforce? _____

4. Does the **Insured** have a reduction in workforce committee? Yes No

If _____ yes, _____ please _____ provide details: _____

5. Were/are impact studies conducted? Yes No

If yes, what were the findings? _____

6. (a) Please provide a breakdown of the number of **Employees** to be affected by the reduction:

Category	Total Number of Employees	Category	Total Number of Employees
Male		Female	
Male White		Female White	
Male Minorities		Female Minorities	
Male Officials & Managers		Female Officials & Managers	
Male Minorities Officials & Managers		Female Minorities Officials & Managers	
Male 40 & Older		Female 40 & Older	
Male Minorities 40 & Older		Female Minorities 40 & Older	

(b) What are the criteria to determine the workforce reduction?
 departmental/specific positions seniority performance arbitrary combination of all
 Please provide details _____

7. (a) Was/is severance available to all **Employees**? Yes No
 If no, please provide details: _____

(b) Is the severance package uniform? Yes No

(c) Please attach severance package details.

8. (a) Were/are the **Employees** required to sign a release for the severance package? Yes No

If yes, does it comply with the Age Discrimination in Employment Act (ADEA) and Older Worker Benefit Protection Act ("OWBPA")? Yes No

(b) Did any **Employee** refuse to sign the release? Yes No

(c) Please provide a copy of any waiver(s) and/or releases(s).

9. (a) Are outplacement services provided? Yes No

If yes, are they provided to all **Employees**? Yes No

10. (a) Are exit interviews conducted? Yes No

(b) Are they standardized? Yes No

(c) Are they documented in writing? Yes No

(d) Do they require the **Employee's** signature? Yes No

11. (a) Were any **Claims** filed, or are any expected to be filed, as a result of this reduction in workforce? Yes No
- (b) Have any of the **Employees** effected by the reduction in workforce previously filed complaints or **Claims** of discrimination, harassment, disability or workers compensation? Yes No
 If yes, please provide details on a separate sheet including the date(s) of the most recent complaint(s) or **Claim(s)** by each such **Employee**.
12. Did the **Insured** consult with outside counsel familiar with employment and labor law regarding the reduction in workforce process? Yes No
 If yes, which law firm was consulted? _____

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 Agent Name

 Agent License Number

 Applicant's Signature

 Date