



LONG TERM CARE

Application &  
Questionnaire

*Employee Benefits  
Errors and Omissions Liability*

1. Named Insured \_\_\_\_\_  
(a) Names of any subsidiary organizations \_\_\_\_\_

2. Address \_\_\_\_\_  
\_\_\_\_\_

3. Effective Date \_\_\_\_\_ Term \_\_\_\_\_

4. Limits of Liability \$ \_\_\_\_\_ Each Claim  
\$ \_\_\_\_\_ Aggregate  
Deductible \$1,000 Each Claim

Current Coverage:  
\_\_\_ Occurrence  
\_\_\_ Claims Made                      Retro Date: \_\_\_\_\_

(A) Limit of Liability on General Liability Policy: \_\_\_\_\_

Policy Number: \_\_\_\_\_

5. Do you have an official full-time Personnel Department? \_\_\_\_\_

6. Do you have an EEOC policy? \_\_\_\_\_

7. Indicate the method by which the Employee Benefit Program is presented to employees.

- (a) Verbally at the time of employment
- (b) Outlined in a printed pamphlet
- (c) Verbally and by printed pamphlet

8. Do employees acknowledge by signature that benefits were reviewed by them?

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

<u>Benefits</u>	<u>When Eligible</u>	<u>Benefits</u>	<u>When Eligible</u>
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10. When benefits become available at a date subsequent to employment, what controls are established to assure that the employee is again contacted?

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11. Are employees, leaving the company, eligible for group health benefits under "Cobra" law? \_\_\_\_\_

12. If yes, what are the procedures for notifying the employees?

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13. Indicate total number of employees (including Retirees) at all locations: \_\_\_\_\_

(a) Number of employees at main location: \_\_\_\_\_

(b) List below the location of branches and indicate number of employees at each location

Branch Location	Number of Employees
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

(c) What percentage increase is anticipated for the coming year? \_\_\_\_\_%

14. Is any hiring of employees done in the branches? \_\_\_\_\_

(a) If yes, by what means does the Personnel Department exercise control over the counseling of branch employees with respect to the benefit program?

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(b) Where are branch benefit records maintained? \_\_\_\_\_

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(c) Is a copy maintained at the Home Office?  Yes  No

15. Has this type of insurance been carried in the past? \_\_\_\_\_

If yes, indicate name of carrier and expiration date \_\_\_\_\_

(a) Were any losses paid or claims made under this or any other similar Policy? \_\_\_\_\_ If yes, give particulars \_\_\_\_\_

16. Indicate below any claims, demands, or legal proceedings, pending against the Insured on account of any act of negligence, error, mistake, or omission in the handling of the employee benefit program.

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Dated \_\_\_\_\_

Applicant \_\_\_\_\_

By \_\_\_\_\_

\_\_\_\_\_  
(Title)

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