Commonwealth Underwriters Ltd.
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ALLIED MEDICAL EMPLOYEE BENEFITS SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

1. Named Insured:______________________________
2. Names of any subsidiary organizations:____________________
3. Address:______________________________

   ____
4. Effective date: ____/____/____ Term:____________________
5. 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:______________________________
6. Do you have an official full-time Personnel Department? ☐ No ☐ Yes
7. Do you have an EEOC policy? ☐ No ☐ Yes
8. Indicate the method by which the Employee Benefit Program is presented to employees:

   ☐ Verbally at the time of employment
   ☐ Outlined in a printed pamphlet
   ☐ Verbally and by printed pamphlet
9. Do employees knowledge by signature that benefits were reviewed by them? ☐ No ☐ Yes
10. List the benefits available to employees and indicate the approximate time when eligible:

Benefits	When Eligible

11. When benefits become available at a date subsequent to employment, what controls are established to assure that the employee is again contacted? ______________________________

12. Are employees leaving the company eligible for group health benefits under "Cobra" law? ☐ No ☐ Yes
If "Yes," what are the procedures for notifying the employees?______________________________

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

    c. What percentage increase is anticipated for the coming year?______________________________

14. Is any hiring of employees done in the branches? ☐ No ☐ Yes
    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 benefit records maintained?______________________________
    c. Is a copy maintained at the Home Office? ☐ No ☐ Yes

15. Has this type of insurance been carried in the past? ☐ No ☐ Yes
If "Yes," indicate name of carrier and expiration date:______________________________

Were any losses paid or claims made under this or any other similar policy? ☐ No ☐ Yes
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:______

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

DECLARATION AND SIGNATURE:
The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

______________________ Applicant's Signature ______________________ Sub-Producer

______________________ Title/Date ______________________ Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.