



# United States Liability Insurance Group

## Medical Providers Protection

### RENEWAL APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.  
THIS APPLICATION IS MADE A PART OF THE POLICY

1. Name of Organization: \_\_\_\_\_

Address: \_\_\_\_\_

2. Total Number of: Full Time Employees: \_\_\_\_\_ Part Time Employees: \_\_\_\_\_

Temporary: \_\_\_\_\_ Independent Contractors: \_\_\_\_\_ Leased: \_\_\_\_\_

3. Has there been a reduction of employees in the past 12 months:  Yes  No

If yes, what percentage? \_\_\_\_\_

4. Is a reduction of employees anticipated in the next 12 months?  Yes  No

If yes, what percentage? \_\_\_\_\_

5. Is a sale, merger or acquisition of any entity anticipated in the next 12 months?  Yes  No

6. How many employees have been involuntarily terminated or laid off in the past 12 months? \_\_\_\_\_

7. Did the Organization have a positive net income over the past 12 months?  Yes  No

If no, Please attach a copy of current financial statement.

8. If insurance was written last year subject to implementation of written employment procedures (including **Third Party Guidelines**), were these employment policies implemented and distributed to all employees?

Yes  No If copies of above procedures were not provided to our Company, please attach a copy.

*Attach any changes or revisions (including Third Party clauses required to be implemented) to the written Employment Procedures or Employee Handbook made in the past 12 months.*

I certify the above is true and representative to the best of my knowledge.

\_\_\_\_\_  
Signature of Owner, Principal, or Partner

\_\_\_\_\_  
Date