Risk Placement Services, Inc.

ILLINOIS CASUALTY COMPANY
A Mutual Insurance Company
225 20th Street, PO Box 5018, Rock Island, IL 61204-5018
309-793-1700 800-445-3726 FAX: 309-793-1707

EMPLOYEE BENEFITS LIABILITY COVERAGE QUESTIONNAIRE

1. Policy/Quote # _____

2. Name of Applicant (Insured) _____

3. Limits Desired: $ _____ Each Employee: $ _____ Aggregate
   Policy is subject to a $1,000 deductible per claim.

4. Policy Period: From _____ To _____

   Retroactive Date: _____

   If the retroactive date is prior to the policy effective date, provide a copy of the prior coverage showing the retroactive date.

5. Number of Employees under programs administered _____

6. Employee Benefit Programs which are covered are (check all applicable):
   - ☐ Group Life Insurance
   - ☐ Group Dental Insurance
   - ☐ Group Accident or Health Insurance
   - ☐ Profit Sharing Plans
   - ☐ Group Optical Insurance
   - ☐ Salary Continuation Plans
   - ☐ Employee Stock Subscription Plans
   - ☐ Travel, Savings or Vacation Programs
   - ☐ Workers' Compensation
   - ☐ Unemployment Insurance Social Security and Disability Benefits Insurance

   Salary Administration Plans are <u>not</u> covered.

7. Are benefit plans jointly administered (i.e., trustees elected or appointed by management and union)? ☐ Yes ☐ No

8. Are benefit plans administered by an outside third party administrator? ☐ Yes ☐ No
   If "Yes", name of Administrator _____; and do they carry errors and omissions liability insurance? ☐ Yes ☐ No

9. On programs permitting employees an option to enroll or not to enroll, does the applicant require a signed acceptance or rejection from each employee? ☐ Yes ☐ No
   If "No", explain _____

   _____

10. If this insurance had been in force during the past five years, would any claim have been presented? (Give details) _____

    _____

    _____

11. Does the applicant have knowledge or information of any occurrence which might give rise to a claim? _____

    _____

    _____

    Prior to binding coverage we will need documentation confirming the retroactive date from the most recent prior carrier.