
**MACS/Risk Purchasing Group
MGA/Human Services Benefits L.L.C.
6750 Alexander Bell Drive
Suite 100
Columbia, MD 21046
800-530-7088/Fax: 410-290-2939**

**Employee Benefits Liability on a Claims-made Basis
Supplemental Application**

1. Named Insured and address: _____

2. Number of Employees: _____
3. Losses and Known Acts, Errors of Omissions (last 5 years)

4. Employee's Benefits Provided. Mark with an "I" for Insured plans. Use an "S" for self-funded or self-insured plans.
- | | |
|----------------------------------|--|
| _____ Group Life | _____ Unemployment Insurance |
| _____ Group Accident | _____ Social Security Benefits |
| _____ Group Health | _____ Workers Compensation |
| _____ Group LTD | _____ Workers Compensation |
| _____ Group Profit Sharing Plans | _____ Disability Benefits (required by states) |
| _____ Pension Plans | _____ Stock Option Plans* |

*Explain eligibility: _____

5. Benefit Plan Administration – Knowledge of Requirements
- a) Personnel who counsel employees about benefits are familiar with the details of the programs shown in item 4 above. Yes No
- b) Benefits personnel are familiar with COBRA requirements. Yes No
- c) All programs are in compliance with COBRA requirements. Yes No

Please explain any "no" responses: _____

WARNING: Any person who knowingly and with intent to defraud any Insurance Company of 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 commits a fraudulent insurance act, which is a crime and subjects such person to a criminal and civil penalties.

Name: _____
Date: _____

Title: _____
Signature: _____

The above signed warrants that he/she is authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the Organization, its subsidiaries and their respective Directors, Officer or other Insured Persons.

Submitter's Contact Information

If this form is being submitted by someone other than the Insured, please provide the submitter's contact information below.

Company Name

Contact Person

Address

Phone

Fax

Email