

APPLICATION FOR TENANT DISCRIMINATION LIABILITY INSURANCE POLICY (Claims Made & Reported Form)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet. 2. Application must be signed and dated by owner, partner or officer. 3. Attach copy of your firm's brochure. THIS IS IMPORTANT. 4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION. (PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a.	Nam	ne of Applicant: _						
b.	Address: Street City State Zip Code							
		\$	Street	City	,	State	Zip Code	
c.	(i)	Contact Persor	ו:					
	(ii)	Address (if diff	erent from above):					
d.	Tele	phone:	Fax:	E-Mail:				
e.	Num	nber of Employee	s: Full time	_ Part time	Office	e Field or On Site:		
f.	Applicant is: [] Partnership/Joint Venture [] Individual Proprietor [] Corporation [] Public Agency [] Other – describe							
g.	If Corporation, state exact name:							
h.	Number of years in business:							
i.	Coverage Requested: Limits Effective Date:							
j.	Coverage Desired:							
	Reimbursement Insurance Expense Only							
	Reimbursement Insurance Loss and Expense							
	Pay on Behalf of Loss and Expense							
k.	Co-insurance desired, if other than 5% stated in policy.							
	Co-insurance is applicable only on judgments and/or settlements.							
I.	Are you part of an affiliated group of entities? [] Yes [] No If yes, describe:							
			5 1					
m.	Ann	ual Revenues: L	ast Year :	Current Yea	ar:	Next Year (est.):		
n.	Property Under Management*:							
	(i)	Number of loca	ations:					
	(ii)	Commercial:						
		Retail:	square fee	et	numbe	er of units		
		Office:	square fee	et	numbe	er of units		
		Industrial:	square fee	et	numbe	er of units		
	(iii)	Residential:						
		Number of Uni	ts					

2. CLAIMS/HISTORY

- b. Attach a narrative with any information that you believe will help expedite the underwriting of this application.

* NOTICE TO APPLICANT: The coverage for which application is being made is limited to liability for only THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED TO THE INSURER DURING THE POLICY PERIOD OR WITHIN 60 DAYS AFTER THE EXPIRATION OF THE POLICY PERIOD.

Applicant warrants that its properties are in compliance with statutory and regulatory requirements for persons with physical disabilities, and that applicant has a policy of non-discrimination in renting of its premises.

REPRESENTATION: I/We represent that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Company/Underwriters evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Markel Shand, Inc., Underwriting Manager for the Company/Underwriters.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A 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.

Name of Applicant	Title (Officer, partner, etc.)		
Signature of Applicant	Date		
Name of Broker:			
Address:	Applicable Surplus Lines Tax payable in addition to premium.		

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.