

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

**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. Name of Applicant: \_\_\_\_\_
- b. Address: \_\_\_\_\_  
Street City State Zip Code
- c. (i) Contact Person: \_\_\_\_\_  
(ii) Address (if different from above): \_\_\_\_\_
- d. Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_
- e. Number of Employees: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Office \_\_\_\_\_ 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.
- l. Are you part of an affiliated group of entities? [ ] Yes [ ] No If yes, describe: \_\_\_\_\_
- 
- m. Annual Revenues: Last Year : \_\_\_\_\_ Current Year: \_\_\_\_\_ Next Year (est.): \_\_\_\_\_
- n. Property Under Management\*:  
(i) Number of locations: \_\_\_\_\_  
(ii) Commercial:  
Retail: \_\_\_\_\_ square feet \_\_\_\_\_ number of units  
Office: \_\_\_\_\_ square feet \_\_\_\_\_ number of units  
Industrial: \_\_\_\_\_ square feet \_\_\_\_\_ number of units  
(iii) Residential:  
Number of Units \_\_\_\_\_

**\*Note: Attach a separate schedule listing properties managed, address, number and type of units.**

o. Are any units either adult-only or senior citizen, or restricted to any other protected classes?.....[ ] Yes [ ] No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

**2. CLAIMS/HISTORY**

- a. Has applicant had any lawsuits or incidents of the type to be covered in the past three years?.....[ ] Yes [ ] No  
If yes, please complete SUPPLEMENTAL CLAIM INFORMATION form.
- 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 Shand Morahan & Company, 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.