

THIS IS AN APPLICATION FOR A CLAIMS-MADE POLICY WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY **CLAIM** FIRST MADE AGAINST THE **INSUREDS** DURING THE **POLICY PERIOD**. NO COVERAGE EXISTS FOR **CLAIMS** FIRST MADE AFTER THE END OF THE **POLICY PERIOD** UNLESS, AND TO THE EXTENT, THE EXTENDED REPORTING PERIOD APPLIES.

I. General Information Please make any applicable changes to the following information.

1. Who is the applicant to be named in Item 1 of the Declarations (the Named Insured)?
 - a. Name: _____
 - b. Street Address: _____
City: _____ State: _____ Zip: _____
 - c. Name of the Officer designated to receive correspondence and notices from the insurer:
Name: _____
Title: _____ e-mail: _____

2. Background Information:
 - a. Nature of Operations: _____
 - b. Does the Applicant own or control any Political Action Committees? Yes: No:
 - c. Was the Applicant's organization created by or is it now controlled by any governmental agency? Yes: No:
 - d. Business Type: Non Profit: For Profit:
 - e. Tax Status: Exempt NonExempt
 - f. Years in Business _____

3. Does the Applicant engage in any of the following activities:

Accreditation Programs	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Certification Programs	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Development or administration of ethics codes, rules or regulations	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Peer Review / Disciplinary Actions	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Sponsorship of Insurance Programs	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Standard Setting	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Collective Bargaining / Labor Negotiations	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Publication / Broadcasting	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>

4. **For-Profit Subsidiaries:**

Please note that coverage for for-profit subsidiaries is only provided specifically by endorsement.

 - a. Does the Applicant have any for-profit subsidiaries? Yes: No:
 - b. Is coverage requested for any for-profit subsidiaries? Yes: No:
 - c. If yes, please complete the following:
 - (i) Name(s) as it/they should appear on the policy: _____
 - (ii) Nature of Operations: _____

II. Financial Information

1. Please provide the following information:

	Current Fiscal Year	Prior Fiscal Year
a. Total Annual Revenue / Income	\$ _____	\$ _____
b. Net Income	\$ _____	\$ _____
c. Total Assets	\$ _____	\$ _____
d. Fund Balance or Member Equity	\$ _____	\$ _____

2. Does the Applicant have a CPA-audited financial statement?
If yes, please complete the following;

Yes: No:

Has the outside auditor rendered a "going concern" opinion?
If yes, please provide details.

Yes: No:

If limit requested is over \$1 million, please attach an audited financial statement.

V. Employment Practices Liability

1. Applicant Employee Information:

a. What is the Applicant's total number of employees including full-time, part-time, loaned and/or leased, temporary or seasonal and volunteers?

Current year	1 year prior	2 years prior

b. Has there been any change in Senior Management positions in the past year?

Yes: No:

c. Of current total employees, how many are highly-compensated (\$75,000 or more per year)? _____

2. Does the Applicant distribute written guidelines, an employee handbook or policies and procedures to all employees?

Yes: No:

3. Does the applicant conduct employee and supervisor training?

Yes: No:

4. Does the Applicant have a full-time human resource manager?

Yes: No:

VI. Fiduciary Liability

PLEASE NOTE: *To be completed only by those applicants seeking Fiduciary Liability Coverage (Single Employer Plans Only; multi-employer and/or union ERISA plans are not covered by this application)*

1. Please indicate the type of plans for which insurance is requested:

Type	Plan Assets
Total Assets of all plans:	

Types: DB = Defined Benefit DC = Defined Contribution P = Pension
 W = Welfare Benefit E = ESOP O= Other

2. Total number of participants (including retirees) enrolled in all plans: _____
3. Have any plans been, or will any plans be terminated, suspended, merged, dissolved, or converted to a cash balance plan within the next 24 months? Yes: No:
 If yes, please provide details
4. Do all plans conform to the standards or eligibility, participation, vesting and other Provisions of the Employee Retirement Income Security Act of 1974 (ERISA) as Amended or similar laws? Yes: No:
5. Are more than 10% of the assets of any plan (other than an ESOP) invested in any securities of or loan to the Applicant, or in any real estate? Yes: No:

1. **If Fiduciary Liability Coverage is requested and the limit requested is over \$1,000,000 please attach the following information:**
- most recent Form 5500; and
 - most recent CPA-audited financial statements for each plan.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly and with intent to defraud any insurance company or 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 MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

This application must be signed by the Executive Director, Chairman of the Board, Chief Executive Officer or by the President.

Signed: _____ Title: _____
Print Name: _____ Date: _____

Please submit this application, when completed, signed and dated to your insurance agent:

Producer Information:

Name:	_____
Contact:	_____
Address:	_____
Phone:	_____
Fax:	_____
e-mail:	_____
License #:	_____