

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

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: _____
 Telephone: _____
 Fax: _____
 Web Address: _____
 - 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:

Trade Association <input type="checkbox"/>	Professional Organization <input type="checkbox"/>
Foundation <input type="checkbox"/>	Labor Organization <input type="checkbox"/>
Museum <input type="checkbox"/>	Governmental Agency <input type="checkbox"/>
Charitable Organization <input type="checkbox"/>	Religious Organization <input type="checkbox"/>
Club <input type="checkbox"/>	Other: _____ <input type="checkbox"/>
 - 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. Year Established: _____

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

Certification or Accreditation Programs	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"/>

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:

Within the last 3 years, have the Applicant's outside auditors:

(i) Stated that there are any weaknesses in the Applicant's system of Internal controls?

Yes: No:

(ii) Rendered a "going concern" opinion?

Yes: No:

III. Current / Prior Insurance Coverage Information

1. Please complete the following for those coverages you currently have or previously had insurance coverage for:

Coverage	Check if "yes"	Limit	Retention	Prior & Pending Litigation Date	Premium	Carrier
D&O Liability	<input type="checkbox"/>					
Fiduciary Liability	<input type="checkbox"/>					
General Liability	<input type="checkbox"/>					

2. Has any claim or notice of potential claim been given to the carrier under any of the above coverages?
If yes, please provide details.

Yes: No:

3. Has the carrier under any of the above coverages indicated an intent not to offer renewal terms?
If yes, please provide details.

Yes: No:

IV. Prior Activity

1. Within the last 3 years, has the applicant, subsidiary, or any person associated with such entities for whom this insurance is being sought, been the subject of or involved in any claim, written demand, notice, proceeding or litigation alleging:

a. Anti-trust, copyright or patent violation?

Yes: No:

b. Violation of ERISA?

Yes: No:

c. Discriminatory practice violation or litigation?

Yes: No:

If yes to a, b, or c above, please provide details.

IV. Prior Activity (cont.)

2. Within the last 3 years, has the applicant, subsidiary, or any person associated with such entities for whom this insurance is being sought, been the subject of or involved in any claim, written demand, notice, proceeding or litigation involving:
- a. Certification or Accreditation Programs? Yes: No:
- b. Peer Review / Disciplinary Actions? Yes: No:
- c. Standard-Setting Activities? Yes: No:
- If yes to a, b, or c above, please provide details.
3. Within the last 3 years, has the applicant, subsidiary, or any person associated with such entities for whom this insurance is being sought, been the subject of or involved in any:
- a. Disciplinary action by any regulatory agency or association? Yes: No:
- b. Administrative proceeding before the Equal Employment Opportunity Commission? Yes: No:
- c. Administrative proceeding before the U.S. Department of Labor including the Office of Federal Contract Compliance Programs (OFCCP)? Yes: No:
- d. Administrative proceeding before any state or local government agency whose purpose is to address employment-related claims? Yes: No:
- If yes to a, b, c, or d above, please provide details.

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?
- | Current year | 1 year prior | 2 years prior |
|--------------|--------------|---------------|
| | | |
- b. Has there been any change in Senior Management positions in the past year? Yes: No:
- In the past two years? Yes: No:
- c. Of current total employees, how many are highly-compensated (\$75,000 or more per year)? _____
2. Does the Applicant have written guidelines or procedures for addressing human resource personnel management in the following areas:
- | | | | |
|--|--|---|--|
| a. Hiring / interviewing | Yes <input type="checkbox"/> No <input type="checkbox"/> | g. Disability Accommodations | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| b. Employee at-will statement and employee contract disclaimer | Yes <input type="checkbox"/> No <input type="checkbox"/> | h. Sexual harassment | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. Discrimination | Yes <input type="checkbox"/> No <input type="checkbox"/> | i. Workplace harassment | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. Discipline | Yes <input type="checkbox"/> No <input type="checkbox"/> | j. New employee orientation | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| e. Employment Evaluations | Yes <input type="checkbox"/> No <input type="checkbox"/> | k. Unlawful harassment or discrimination of third parties | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| f. Termination Procedures | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
3. Does the Applicant conduct employee and supervisor training in the areas mentioned above? Yes: No:
4. Does the Applicant distribute written guidelines, an employee handbook or policies and procedures to all employees? Yes: No:
5. 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 participant (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:

VII. Requested Coverage Information

Proposed Effective Date:	
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Requested Limit:	D&O	
	FIDUCIARY	

NOTES:

1. **If limit requested is over \$1,000,000 please attach the following information:**
 - a. audited financial statement from the last two (2) years; and
 - b. current employee handbook.
2. **If Fiduciary Liability Coverage is requested and the limit requested is over \$1,000,000 please attach the following information:**
 - a. most recent Form 5500; and
 - b. most recent CPA-audited financial statements for each plan.



VIII. WARRANTY

Please Note: *If applicant currently purchases a CNA Not-for-Profit D&O policy then this Warranty Section is inapplicable.*

None of the natural persons or entities to be insured under the policy are responsible for or have knowledge of any **Wrongful Act** or fact, circumstance or situation which they may have reason to suppose might result in a future claim, except as follows:

Check one box below:

- A. **There are Exceptions to the Warranty** *Please attach details*
- B. **There are no exceptions to the Warranty** *Check here if there are no exceptions to the Warranty*

1. It is agreed by all concerned that if any of the Insured Persons is responsible for or has knowledge of any wrongful act, fact, circumstance, or situation which (s)he has reason to suppose might result in a future claim, whether or not described above, any claim subsequently emanating therefrom shall be excluded from coverage under the proposed insurance as to (i) such of the insured persons and (ii) the applicant, subsidiaries and the plan if such insured persons are executive officers. The responsibility or knowledge of any individual shall not be imputed to any other individual for the purposes of determining the availability of coverage.
2. It is declared that this application and any materials submitted or required (which shall be maintained on file by the Insurer and be deemed attached as if physically attached to the proposed Policy) are true and are the basis of the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.
3. The undersigned declares that to the best of his/her knowledge the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information from all of the insured Persons to facilitate the proper and accurate completion of this application for the proposed Policy. Signing of this application does not bind the undersigned to purchase the insurance, but it is agreed that this application shall be the basis of the contract should a Policy be issued, and this application will be attached to and become part of such Policy. The undersigned agrees that if after the date of this application and prior to the effective date of any based on this application, any occurrence, event or other circumstance should render any of the information contained in this application inaccurate or incomplete, then the undersigned shall notify the Insurer of such occurrence, event or circumstance and shall provide the Insurer with information that would complete, update or correct such information. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Insurer.
4. The information requested in this application is for underwriting purposes only and does not constitute notice to the Insurer under any Policy of a claim or potential claim. All such notices must be submitted to the Insurer pursuant to the terms of the Policy, if and when issued.

The undersigned acknowledges that he or she is aware that defense costs reduce and may exhaust the applicable Limits of Liability. The Insurer is not liable for any loss (which includes defense costs) in excess of the applicable Limits of Liability.

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.



APPLICATION Not-for-Profit

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

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

Victor O. Schinnerer
Two Wisconsin Circle
Chevy Chase, Maryland 20815-7022

Phone: 301-961-9800
Fax: 301-951-5444
Web Address: www.schinnerer.com

Producer Information:

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