Non Profit Professional Liability Application - All States

Applicant may qualify for an INSTANT QUOTE by completing Section I below. Section II answers will be required prior to binding and are subject to underwriting approval.

This is an application for a claims made policy - Please read your policy carefully. Application for Non Profit Directors & Officers Liability Insurance (Coverage Part A) and Employment Practices Liability Insurance (Optional Coverage Part B) and Fiduciary Liability Insurance (Optional)

I. INSTANT QUOTE INFORMATION

Instant quote is not available for accounts with losses in the past 5 years. If there is a loss history, please complete Section I. and submit details in a claim supplement.

Applicant's Name: _____

Location Address: _____ ☐ Same as mailing address or complete section III.

City: _____ State: _____ Zip: _____

Web Address: _____ Email Address of primary contact: _____

Description of Operations:

Total Annual Revenue: _____ (If >$2 million attach the most recent 12-month financial statement)

If less than 3 years in operation, annual revenue: this year : _____ next year: _____ 3rd year: _____

Total Fund Balance (Total Assets minus Total Liabilities): _____

Full Time Employees: _____ Part Time: _____ Temporary/Seasonal: _____ Volunteers: _____

Does the organization perform any operations located outside the U.S.? _____ In Existence Since: _____

II. UNDERWRITING INFORMATION

1. Does the organization have an anti-harassment and anti-discrimination policy ☐ Yes ☐ No
2. Does the organization have tax exempt status by the I.R.S.? ☐ Yes ☐ No
3. Does the organization have General Liability Insurance? ☐ Yes ☐ No
4. Expiring Information: Carrier _____ Limits _____ Retention _____ Premium _____

(Attach a statement of details for all "yes" answers to the following questions)

5. Is any entity proposed for Insurance involved in any of the following:
   a) Research, development or testing? ☐ Yes ☐ No
   b) Certification, accreditation or standard-setting? ☐ Yes ☐ No
   c) Disciplinary actions as a result of peer review activities? ☐ Yes ☐ No
   d) Administration or sponsorship of any insurance programs? ☐ Yes ☐ No
   e) Labor/union negotiations or collective bargaining? ☐ Yes ☐ No
6. Does the Applicant have any chapters or subsidiaries requiring coverage? ☐ Yes ☐ No
7. Has any entity proposed for Insurance closed, downsized, laid off, reduced staff, sold, merged with or acquired any company in the past 12 months or anticipates doing so in the next 12 months? ☐ Yes ☐ No
8. a) Within the last 5 years, has any inquiry, complaint, notice of hearing, claim or suit been made against any entity proposed for Insurance, or any person proposed for Insurance in the capacity of Director, Officer, Trustee, Employee or Volunteer of any entity proposed for Insurance? ☐ Yes ☐ No
   b) Is any person(s) proposed for this Insurance aware of any fact, circumstance or situation which may result in a claim against any entity proposed for Insurance or any of its Directors, Officers, Trustees, Employees or Volunteers? ☐ Yes ☐ No
9. Has any Policy for Directors and Officers or Employment Practices Liability ever been cancelled or non-renewed? ☐ Yes ☐ No
   (Do not answer if applicant is located in Missouri)

III. ADDITIONAL APPLICANT INFORMATION

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

New York Disclosure Notice: This policy is written on a claims made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged Wrongful Acts or Wrongful Employment Acts that took place prior to retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect for incidents reported during the Policy Period or any subsequent renewal of this Policy or any extended reporting period and all coverage under the policy ceases upon termination of the policy except for the automatic extended reporting period coverage unless the insured purchases additional extend reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The Insured may

purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.

Virginia Notice: This Policy is written on a claims-made basis. Please read the policy carefully to understand your coverage. You have an option to purchase a separate limit of liability for the extended reporting period,. If you do not elect this option, the limit of liability for the extended reporting period shall be part of the and not in addition to limit specified in the declarations. If you have any questions regarding the cost of an extended reporting period, please contact your insurance company or your insurance agent. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

Minnesota Notice: Authorization or agreement to bind the insurance may be withdrawn or modified only based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for nonpayment of premium.

Florida and Illinois Notice: I understand that there is no coverage for punitive damages assessed directly against an insured under Florida and Illinois law. However, I also understand that punitive damages that are not assessed directly against an insured, also known as "vicariously assessed punitive damages", are insurable under Florida and Illinois law. Therefore, if any Policy is issued to the Applicant as a result of this Application and such Policy provides coverage for punitive damages, I understand and acknowledge that the coverage for Claims brought in the State of Florida and Illinois is limited to "vicariously assessed punitive damages" and that there is no coverage for directly assessed punitive damages

Colorado Fraud Statement: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Fraud Statement: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Fraud Statement: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky Fraud Statement: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine and Washington Fraud Statement: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Jersey Fraud Statement: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York Fraud Statement: 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 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.

Ohio Fraud Statement: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Fraud Statement: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania Fraud Statement: 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 subjects such person to criminal and civil penalties.

Tennessee and Virginia Fraud Statement: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Vermont Fraud Statement: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be subject to fines and confinement in prison.

Fraud Statement (All Other States): Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If your state requires that we have information regarding your Authorized Retail Agent or Broker, please provide below.

Retail Agency Name: _____ License #: _____

Main Agency Phone Number: _____

Agency Mailing Address: _____

City: _____ State: _____ Zip Code: _____

The signer of this application acknowledges and understands that the information provided in this Application is material to the Insurer's decision to provide the requested insurance and is relied on by the Insurer in providing such insurance. The signer of this application represents that the information provided in this Application is true and correct in all matters. The signer of this Application further represents that any changes in matters inquired about in this Application occurring prior to the effective date of coverage, which render the information provided herein untrue, incorrect or inaccurate in any way will be reported to the Insurer immediately in writing. The Insurer reserves the right to modify or withdraw any quote or binder issued if such changes are material to the insurability or premium charged, based on the Insurer's underwriting guides. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the Policy.

Applicant's Signature: _____ Title: _____ Date: _____

President, Chairperson of the Board, or Executive Director

FIDUCIARY LIABILITY SUPPLEMENTAL QUESTIONNAIRE

1. Name of Organization:_____
   State:_____

2. Please check all plans the Organization currently sponsors for its employees:

   401K Plan_____ 403B Plan_____ Pension Plan____ Medical/Dental_____

   Life Insurance_____ Disability_____ Other: Please describe:_____.

3. If you have either a 401K, 403B, Life Insurance or Pension Plan:

   (a) Does an Outside Investment Firm manage the Plans? Yes_____ No_____.
   If Yes, how often is their performance reviewed? _____.

   (b) Has a Lawyer, CPA or Actuary reviewed the Plans to assure there are no violations of prohibited transactions/Party-in-interest rules and to verify compliance with standards of eligibility, participation, vesting, funding and other provisions of the Employee Retirement Income Security Act of 1974 (E.R.I.S.A) and similar provisions?
   Yes_____ No_____. If Yes, when was the last time Plans were reviewed?_____.

4. If you have either a Medical/Dental or Disability Plan, does an outside Administrative or Benefits Consulting Firm administer the Plan(s)? Yes_____ No_____.

5. In the past two (2) years has there been or is there now under consideration any material changes to a Plan or termination/consolidation of a Plan? Yes_____ No_____. If Yes, please attached details.

6. Has there been or is there now pending any claim(s) against any proposed Insured arising out of any Plan? Yes _____ No_____. If Yes, please attach details.

7. Does any proposed Insured have knowledge or information of any act, error or omission which might give rise to a claim under the proposed Fiduciary Liability Coverage? Yes____ No_____ If Yes, please attach details.

The information on this supplemental questionnaire is material to the Company underwriting this risk and shall be deemed attached a part of this Policy as is physically attached hereto.

Signature:_____ Title:_____ Date:_____
Must be signed by Chairman, President or Executive Director.