



## Hiscox Not-for-Profit Management Liability Application Renewal Business Application

**NOTICE: THE LIABILITY COVERAGE PARTS OF THIS POLICY (WHICHEVER ARE PURCHASED) PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD OR AN APPLICABLE EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY DEFENSE COSTS. DEFENSE COSTS WILL BE APPLIED AGAINST THE RETENTION. IN NO EVENT WILL THE INSURER BE LIABLE FOR DEFENSE COSTS OR THE AMOUNT OF ANY DAMAGES OR SETTLEMENT IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.**

**Requested Coverage**

Available Coverage Parts	Applying for Coverage?	Limit of Liability Requested	Separate or Shared Limit with	Retention Requested	Entity or No Entity Coverage
Directors & Officers Liability		\$		\$	
Employment Practices Liability		\$		\$	
Fiduciary Liability		\$		\$	
Employed Lawyers Professional Liability		\$		\$	

**General Information**

1. Name of Applicant:
2. Address of Applicant:
3. State of Incorporation:
4. Years in Operation:
5. Nature of Operations:
6. Name of Risk Manager (or equivalent position):   
 Title:   
 Time in Position:   
 Email address:
7. Does the Applicant have tax-exempt status under the U.S. Internal Revenue Code or applicable State codes? Yes  No   
 If yes, please list the applicable code:
8. Has the applicant or any subsidiary engaged in any mergers or acquisitions in the last three (3) years? Yes  No



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- Are there any plans for mergers or acquisitions in the next 12 months? Yes  No
9. Has any insurance carrier refused, cancelled, or non-renewed any coverage for which this applicant is applying for? **\*\*\*Missouri Applicants need not reply.** Yes  No
10. Has the Applicant changed its outside auditor in the last 24 months or is it contemplating a change in the next 12 months? Yes  No   
If yes, please provide additional details on a separate attachment.
11. Is the Applicant seeking coverage for punitive damages? Yes  No
12. Is any of the Applicant's liability insurance coverage self-insured, or insured through a trust, captive or reciprocal risk sharing operation? Yes  No   
If yes, please provide additional details on a separate attachment.

13. Please list all Subsidiaries

Name of Subsidiary	Business Type	% of Ownership	Date Acquired or Created	Public Co, Private Co or NFP Org

Provide list of Subsidiaries on a separate attachment if necessary.

Are you requesting coverage to extend to all Subsidiaries? Yes  No

### Claims Information

1. On a separate attachment, please provide a loss run for the last three (3) years. If none, check here

### Financial Information

1. Please provide the following information for the Applicant and its Subsidiaries:

Date of Financial Statement:	
Total Assets:	\$
Total Liabilities:	\$
Current Assets:	\$
Current Liabilities:	\$
Fund Balance:	\$
Total Revenues:	\$
Net Income or Net Loss	\$
Net Income or Net Loss	\$

2. Please provide the percentage of revenues that the Applicant or any subsidiary receives from the government sources.

<b>Source:</b>	%
<b>Source:</b>	%
<b>Source:</b>	%

3. Has the Applicant or any subsidiary issued any debt subsequent to the completion of the financial statements submitted to the Insurer as part of this Application? Yes  No



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4. Does the Applicant or any Subsidiary have any plans to issue any debt in the next twelve months? Yes  No
- If yes, please provide additional details on a separate attachment.

### Directors and Officers Liability Coverage Application

Please complete this section only if applying for this coverage

1. Please attach a list of all members of the Applicant's Board of Directors including name, affiliation and date of nomination.
2. Are the members of the Applicant's Board of Directors elected or selected?
3. How many board meetings does the Applicant's Board of Directors hold on a yearly basis?
4. Does the Applicant or any Subsidiary provide childcare or daycare services? Yes  No
5. Does the Applicant or any subsidiary render any professional services or engage in any standard setting, accrediting, credentialing or licensing activities? Yes  No
6. Does the Applicant's Board of Directors have the following committees?
 

Compensation Committee	Yes <input type="checkbox"/> No <input type="checkbox"/>
Audit Committee	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nominating Committee	Yes <input type="checkbox"/> No <input type="checkbox"/>

### Healthcare Institutions

Please complete this section if the Applicant's nature of operations include any healthcare related activities

1. Please select the option that best describes the Applicant or any Subsidiary's healthcare activities:
 

<input type="checkbox"/> Nursing Home/Retirement Home	<input type="checkbox"/> Drug Rehabilitation Center
<input type="checkbox"/> Stand-alone Hospital	<input type="checkbox"/> Multi-location Healthcare System
<input type="checkbox"/> Managed Care Organization	<input type="checkbox"/> Other:
  2. Please select the option that best describes hiring practices with respect to physicians:
 

<input type="checkbox"/> Physicians are employed by the Applicant or a Subsidiary
<input type="checkbox"/> Physicians are independent contracts and are granted privileges to practice
<input type="checkbox"/> Physicians may be either employed by or independent contractors of the Applicant or a Subsidiary
<input type="checkbox"/> The Applicant or a Subsidiary does not employ physicians or grant privileges for physicians
  3. Does the Applicant or any Subsidiary contract with third parties to manage, operate, or administer its facilities? Yes  No
  4. Has the Applicant or any Subsidiary voluntarily disclosed to any regulatory entity that it is aware of any potential violations of the Civil False Claims Act, The Stark Act or similar laws or regulations related to the healthcare field? Yes  No
- If yes, please provide additional details on a separate attachment.



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### Education Institutions

Please complete this section if the Applicant's nature of operations includes Education related activities

1. Please select the option that best describes the Applicant or any Subsidiary's nature of operations:

<input type="checkbox"/> Public School District	<input type="checkbox"/> Private Primary of School
<input type="checkbox"/> Charter School	<input type="checkbox"/> Boarding School
<input type="checkbox"/> Vocational/Technical School	<input type="checkbox"/> Junior/Community College
<input type="checkbox"/> 4-Year Public College/University	<input type="checkbox"/> 4-Year Private College/University
<input type="checkbox"/> Law/Medical School	<input type="checkbox"/> Other:

2. Has the Applicant or any Subsidiary closed, reduced or discontinued any programs, campuses or majors or is planning to do so within 24 months? Yes  No

3. Has any accreditation body threatened or taken any probationary or censure action against the Applicant or any Subsidiary? Yes  No

If yes, please provide additional details on a separate attachment.

4. Most current accreditation(s):

<b>Date:</b>	<input style="width: 90%;" type="text"/>	<b>Body:</b>	<input style="width: 90%;" type="text"/>
<b>Date:</b>	<input style="width: 90%;" type="text"/>	<b>Body:</b>	<input style="width: 90%;" type="text"/>

### Labor Union Organization

Please complete this section if the Applicant's nature of operations is related to labor union activity

Name of Local:

National or International Affiliation:

### Employment Practices Liability Coverage Application

Please complete this section only if applying for this coverage

1. Please enter the total number of employees in the boxes below.

Type of Employee	Domestic Union	Domestic Non-Union	
Full time – based in California			
Part time – based in California			
Full time – based in FL, MI, TX and Washington DC			
Part time – based in FL, MI, TX and Washington DC			
Full time – all other states			
Part time – all other states			
Total – All States			
Volunteers			
Full time Foreign Employees			
Part time Foreign Employees			
Leased Employees			
Independent Contractors			



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Seasonal Employees		
Temporary Employees		

2. What was the annual employee turnover rate for the last three years?

Past Year:	1 Year Prior:	2 Years Prior:
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3. Does the Applicant have a Human Resources Department, Personnel Department or Human Resources Director? Yes  No
4. Is an employee handbook distributed to employees of the Applicant and any Subsidiary either in hard copy or via the Internet, which informs the employees of their employment rights? Yes  No   
 If yes, are employees required to certify that they have reviewed the employee handbook and will comply with the terms and conditions? Yes  No
5. Has the Applicant or any Subsidiary undergone or will it be undergoing any of the following employment activities?  
 Layoffs over the last three years? Yes  No   
 Currently ongoing layoffs? Yes  No   
 Layoffs expected in the next 12 months? Yes  No   
 If yes to any of the above, please provide additional details on a separate attachment.
6. Does the Applicant or any Subsidiary use outside counsel to handle the layoff process (including any "reduction in force")? Yes  No
7. Is it the policy of the Applicant or any Subsidiary to offer severance packages in exchange for releases not to sue? Yes  No
8. Is there a formal process for employees to report complaints, which states that the reporting of these matters will not result in disciplinary or retaliatory action? Yes  No
9. Is the Applicant seeking non-employment (third party) discrimination coverage? Yes  No
10. Has the Applicant or any Subsidiary ever had a claim brought against it by a non-employee third party alleging harassment, discrimination or any violation of civil rights? Yes  No   
 If yes, please provide additional details on a separate attachment.
11. Does the Applicant or any Subsidiary have established policies or procedures detailing employee conduct when dealing with third parties, including non-discrimination statements? Yes  No

### Fiduciary Liability Coverage Application

Please complete this section only if applying for this coverage

1. Please complete the following grid for the five (5) largest Plans which the Applicant is seeking coverage for:

Full Name of Plan	Total Number of Plan Participants	Active Number of Plan Participants	Total Plan Assets	Type of Plan*
			\$	
			\$	
			\$	
			\$	



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		\$
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\*Types of Plans: Employee Stock Ownership Plan = ESOP  
 Defined Contribution Plan = DC  
 Welfare Benefit Plan = WB

Defined Benefit Plan = DB  
 Excess Benefit Plan = EB

2. Is any Plan listed in Question #1 a multiemployer or multiple employer plan? Yes  No   
 If yes, please provide additional details on a separate attachment, including past and anticipated future Plan merger activity (if any).
3. What percentage of Plan assets are managed by an investment manager as defined in ERISA? %
4. How often is the Plan's investment manager's performance reviewed?
5. How often do the fiduciaries amend the investment manager's guidelines and goals for the Plans listed in Question #1?
6. In the last two (2) years, has the Applicant or any Subsidiary amended, merged or terminated any Plan and is any such event contemplated within the next two (2) years? Yes  No   
 If yes, please provide additional details on a separate attachment.
7. Does the Applicant or any Subsidiary have any outstanding delinquent contributions to any Plan? Yes  No   
 If yes, please provide additional details on a separate attachment.
8. If any Plan listed in Question #1 is sponsored by a government entity, does such Plan contain any "DROP" feature? Yes  No   
 If yes, please provide additional details on a separate attachment.
9. Does any Plan listed in Question #1 hold or invest in securities of the sponsor organization or of any Subsidiary or Affiliate? Yes  No   
 If yes, please provide additional details on a separate attachment.
10. Have any fees, fines or penalties been assessed against any Plan of the Applicant or any subsidiary under any voluntary compliance program or similar voluntary settlement program? Yes  No   
 If yes, please provide additional details on a separate attachment.

### Employed Lawyers Professional Liability Coverage Application

Please complete this section only if applying for this coverage

1. Please provide the number of lawyers employed by the Applicant or any Subsidiary in their capacity as such for the Organization:
2. What is the average number of years of experience of the Applicant's or any Subsidiary's employed lawyers?
3. Do the Applicant's or any Subsidiary's employed lawyers conduct *pro bono* or work on behalf of the Applicant or any Subsidiary? Yes  No
4. Do the Applicant's or any Subsidiary's employed lawyers perform moonlighting services to parties other than the Applicant or any Subsidiary? Yes  No
5. Does the Applicant or any Subsidiary permit or require its employed lawyers to issue written legal opinions to outside parties? Yes  No



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6. Do any of the Applicant's or any Subsidiary's employed lawyers serve on the Board of Directors of the Applicant or any Subsidiary? Yes  No
7. Do any of the Applicant's or any Subsidiary's employed lawyers perform any securities related to legal work on behalf of the Applicant or any Subsidiary? Yes  No   
If yes, please provide additional details on a separate attachment.

**Current or Prior Insurance Information**

Coverage	Coverage In Place	Expiration Date	Limit of Liability	Retentions	Carrier	Continuity Date	Premium
Directors & Officers	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	\$			
Employment Practices	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	\$			
Fiduciary	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	\$			
Employed Lawyers	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	\$			

**WE REQUIRE THE FOLLOWING INFORMATION IN ADDITION TO THIS APPLICATION:**

- Latest consolidated financial statement of the Applicant with Treasurer's warranty letter if the financials are not audited.
- If applying for Fiduciary Liability coverage, please provide information for the five largest pension Plans, including copies of the most recent audited financial statements. If the plan assets are held in a master trust, please submit details on master trust investment portfolio. If exempt from filing audited financial statement, please provide the most recent Form 5500 for each plan, with all attachments.
- Copy of the Applicant's Employee Handbook or manual or link to the appropriate section of the Applicant's website.

Without prejudice to any other rights and remedies of the Insurer, the Applicant understands and agrees that if any fact, circumstance or situation exists, whether or not disclosed in this Application, any claim or action arising from any such fact, circumstance or situation is excluded from coverage under the proposed policy, if issued by the Insurer.

If there is any material change in the answers to the questions in this Application before the proposed policy inception date, the Applicant must notify the Insurer in writing and any outstanding quote for insurance coverage may be modified or withdrawn.

The Applicant's submission of this Application does not obligate the Insurer to issue, or the Applicant to purchase a policy. The Applicant authorizes the Insurer to make any inquiry in connection with this Application.

All written statements and materials furnished to the Insurer in conjunction with this Application are hereby incorporated into this Application and made a part hereof.

The undersigned authorized agents of the Applicant declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application are true and complete. The undersigned agree that this Application shall be the basis of the insurance policy should an insurance policy providing the requested coverage be issued and that the Insurer will have relied on the Application in issuing any policy.



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**NOTICE TO APPLICANTS:** 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS:** 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.

**NOTICE TO COLORADO APPLICANTS:** 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 INSURANCE 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 AUTHORITIES

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** 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.

**NOTICE TO FLORIDA APPLICANTS:** 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 IN THE THIRD DEGREE.

**NOTICE TO KENTUCKY APPLICANTS:** 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.

**NOTICE TO LOUISIANA APPLICANTS:** 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.

**NOTICE TO MAINE APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE INSURANCE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**NOTICE TO MARYLAND APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO NEW JERSEY APPLICANTS:** ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO OHIO APPLICANTS:** 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.

**NOTICE TO OKLAHOMA APPLICANTS: 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





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ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

**NOTICE TO PENNSYLVANIA APPLICANTS:** 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.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE INSURANCE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**NOTICE TO VERMONT APPLICANTS:** 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO NEW YORK APPLICANTS:** 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.

Signature:

Applicant

Date:

Title:

(Must be signed by President, Chairman, Chief Executive Officer, Chief Financial Officer, Executive Director, Corporate Risk Manager or General Counsel)

Signature of Producer

Date

Address of Producer

Producer's License Number



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**THE FOLLOWING APPLIES TO APPLICANTS LOCATED IN THE STATES OF AR, MO, NY, NM and RI:**

Please read the following statement carefully and sign where indicated. If a policy is issued, this signed statement will be attached to the policy.

The undersigned authorized officer of the Applicant hereby acknowledges that he/she is aware that the limit of liability contained in this policy shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability of this policy.

The undersigned authorized officer of the Applicant hereby acknowledges that he/she is aware that legal defense costs that are incurred shall be applied against the retention amount.

Signature:

Applicant

Date:

Title:

(Must be signed by President, Chairman, Chief Executive Officer, Chief Financial Officer, Executive Director, Corporate Risk Manager or General Counsel)