

Nonprofit Management Liability Insurance

CLAIMS MADE WARNING FOR APPLICATION: This Proposal Form is for a Claims Made and Reported Policy, relating to claims made against the Insureds during the Policy Period or the Extended Reporting Period, if applicable.

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the Policy. This Proposal Form is to be completed with respect to the entire Insured Entity. Insured Entity as used herein is defined to include the Named Insured and any Subsidiaries.

Name of Named Insured

Street Address Suite

City County State Zip Code

Website Address (if applicable) Federal Employer Identification Number (FEIN)

The person designated as agent of the Insured Entity and of all Insureds to receive any and all notices from the Insurer or their authorized representatives concerning this insurance:

Contact Name Title

E-mail Address Telephone Number Fax Number

Producer Information

Submitted by (Agency Name) Dated

Agent's Name (Individual's Name) Agent's License Number

Coverage Desired

Directors, Officers and Organization Liability Insurance Coverage Section: [] Yes [] No Limit Requested: \$
Employment Practices Liability Insurance Coverage Section: [] Yes [] No Limit Requested: \$
Fiduciary Liability Insurance Coverage Section: [] Yes [] No Limit Requested: \$

Indicate the type of limit requested: [] Combined Aggregate Limit of Liability for all Coverage Sections, or
[] Separate Aggregate Limit of Liability for each Coverage Section

Current Insurance Information

1. Provide the following information regarding the Insured Entity's most recent insurance policies. If "None", so state.

Table with 6 columns: Type of Policy, Insurance Carrier, Expiration Date, Limit of Liability, Deductible, Premium. Rows for Directors and Officers Liability, Employment Practices Liability, and Fiduciary Liability.

2. Within the last 3 years, has any Claim been made or has notice been given under any of the previous policies for Directors and Officers Liability, Employment Practices Liability or Fiduciary Liability insurance or similar insurance? [] Yes [] No

3. Within the last 3 years, has any Directors and Officers Liability, Employment Practices Liability, Fiduciary Liability insurance, or similar insurance policies for the Insured Entity ever been cancelled or non-renewed? (NOT APPLICABLE IN MISSOURI) [] Yes [] No

Prior Knowledge Information

4. Is any Insured aware of any fact, circumstance or situation involving any Insureds that might reasonably be expected to result in a Claim for each applicable Coverage Section indicated above? [] Yes [] No

IF "YES" TO QUESTION 4., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

(a) Date Claim first made (b) Claimant's Name (c) Allegation (d) Current Status
(e) Demand Amount (f) Settlement (Indemnity) or Reserve Amount (g) Attorney's fees

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTION 4.

Directors, Officers and Organization Liability Insurance Coverage Section

5. (a) Does the **Insured Entity** currently have a tax-exempt status under the U.S. Internal Revenue Service Code? Yes No
 If "Yes", under which IRSC Section? _____
 If "No", provide an explanation: _____
- (b) Have there been or are there now pending, any disputes as to the **Insured Entity's** tax-exempt status? Yes No
6. The **Named Insured** has been in continuous operation since: _____
7. Describe the **Insured Entity's** nature of operations: _____
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8. Does the **Insured Entity** own or hold any patents? If "Yes", how many? _____ Yes No
9. Does the **Insured Entity**:
- (a) provide any professional services including, but not limited to, legal counseling, medical care, peer review and credentialing activities to others? Yes No
- (b) promote, sponsor or provide any form of insurance to its members or non-members? Yes No
- (c) transact electronic commerce on behalf of itself, members or third parties? Yes No
- (d) have a membership in any nonprofit or professional associations? If "Yes", provide association names below. Yes No

10. Provide the following information on all **Subsidiaries** or related organizations of the **Insured Entity**. If "None", so state. None

<u>Subsidiary or</u> <u>Organization Name</u>	<u>Nature of Business</u>	<u>Not For Profit?</u>	<u>Total</u> <u>Assets</u>	<u>Is coverage requested for</u> <u>this entity under this Policy?</u>
_____	_____	<input type="checkbox"/> Yes, IRSC: _____ <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes, IRSC: _____ <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES OR RELATED ORGANIZATIONS IN QUESTION 10. UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED.

11. Provide the following financial information with respect to the **Insured Entity**: Period Ending: _____ / _____ / _____
 Assets (000): \$ _____ Fund Balance* (000): \$ _____ Annual Revenues (000): \$ _____
 *Fund Balance equals Total Assets minus Total Liabilities
12. (a) Is the **Insured Entity** currently in bankruptcy? Yes No
 (b) Within the next 12 months, is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code? Yes No
13. Within the last 3 years, have there been resignations, departures, retirements, or terminations in the position of the Chairperson of the Board of Directors, President, Chief Executive Officer, Executive Director, or Chief Financial Officer that fall outside of the scope of annual elections or bylaws? Yes No
 If "Yes", provide the following details by attachment: Name of individual; date of change; and reason for change.
14. During the last 5 years, has the **Insured Entity** or any of the **Insured Persons** received any written demands for monetary or non-monetary relief, been involved in, or had any knowledge of any civil or criminal action, administrative or arbitration proceeding, including both domestic or foreign equivalents, involving:
- (a) any intellectual property disputes, including Copyright, Patent, or Trademark Laws? Yes No
- (b) any alleged violation of any Federal or State Security Law or Regulation? Yes No
- (c) any alleged violation of any Federal or State Anti-Trust or Fair Trade Law? Yes No
- (d) any other allegations of violations of federal, state or local statute, regulation, ordinance or common law that would otherwise be within the scope of this proposed insurance? Yes No

IF "YES" TO ANY PART OF QUESTION 14., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

(a) Date Claim first made	(b) Claimant's Name	(c) Allegation	(d) Current Status
(e) Demand Amount	(f) Settlement (Indemnity) or Reserve Amount	(g) Attorney's fees	

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTION 14.

Employment Practices Liability Insurance Coverage Section (Complete this section if this coverage is desired)

15. Number of Employees:	<u>Full Time</u>	<u>Part Time</u>	<u>Leased</u>	<u>Seasonal and/or Temporary</u>	<u>Volunteers and/or Interns</u>	<u>Independent Contractors</u>	<u>Annual Turnover Rate</u>
	Current Year:						
Last Year:							

16. Indicate which formal written policies and procedures have been implemented. If "None", so state. None
- Employee Handbook / Manual Anti-Harassment Policy, including Employers with more than 50 Employees
 Sexual Harassment Family Medical Leave Act
- Anti-Discrimination Policy – Equal Employment Opportunity (EEO) Policy Adherence to Employment "at-will" relationship with all **Employees** California Employers Only
 California Family Rights Act
17. During the last 5 years, has any **Insured** known of, or been involved in any lawsuit, charges, inquiries, investigations, grievances or other administrative hearings or proceedings before any of the following agencies and/or in any of the following forums, including both domestic or foreign equivalents?
- (a) National Labor Relations Board? Yes No
- (b) Equal Employment Opportunity Commission? Yes No
- (c) Office of Federal Contract Compliance Programs? Yes No
- (d) U.S. Department of Labor? Yes No
- (e) Any state or local government agency such as the Labor Department or fair employment agency? Yes No
- (f) U.S. District or state court? Yes No
18. During the last 5 years, has any current or former **Employee** or third party made any Claim, or otherwise alleged discrimination, harassment, wrongful discharge and/or **Wrongful Acts** against any **Insured**? Yes No
- A Claim is not limited to the filing of a lawsuit or complaint with the Equal Employment Opportunity Commission or similar state or local agency. A Claim may also include a written demand by any current or former **Employee** seeking relief in connection with an employment-related dispute or grievance.

IF "YES" TO ANY PART OF QUESTIONS 17., OR 18., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

(a) Date Claim first made	(b) Claimant's Name	(c) Allegation	(d) Current Status
(e) Demand Amount	(f) Settlement (Indemnity) or Reserve Amount	(g) Attorney's fees	

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTIONS 17., OR 18.

Fiduciary Liability Insurance Coverage Section (Complete this section if this coverage is desired)

19. Provide the following information regarding each employee welfare benefit plan, employee pension benefit plan or pension plan, as defined by **ERISA**, (hereinafter referred to as **Employee Benefit Plans**) which the **Insured Entity** maintains or to which it contributes.

<u>Name of Plan</u>	<u>Type of Plan*</u>	<u>Name of Plan Sponsor</u>	<u>Number of Plan Participants</u>	<u>Fair Market Value of Plan Assets</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Type of Plan: (DB)=Defined Benefit; (DC)=Defined Contribution; (ESOP)=Employee Stock Ownership Plan; (WB)=Health & Welfare Benefit; (MEP)=Multi Employer Plan or Multiple Employer Plan; (O)=Other

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR EMPLOYEE BENEFIT PLAN(S) IN QUESTION 19. FOR WHICH THE ABOVE INFORMATION IS INCOMPLETE OR NOT PROVIDED.

20. Has any **Employee Benefit Plan** loaned or pledged any **Employee Benefit Plan** assets to any party-in-interest (including the **Insured Entity**)? If "Yes", provide details by attachment. Yes No
21. Are there any overdue employer contributions for any plan, or has any plan requested or contemplated filing a request for a waiver of contributions? If "Yes", provide plan name and amount of overdue contributions by attachment. Yes No
22. Within the last 3 years, has there been, or is there currently under consideration, any restructuring, termination or other similar transaction of any **Employee Benefit Plan**? If "Yes", provide the details of the transaction by attachment. Yes No

23. If any of the following questions are answered "No", provide details by attachment.
- (a) Are all **Employee Benefit Plans** compliant with the Health Insurance Portability and Accountability Act ("HIPAA")? Yes No
 - (b) Does the plan sponsor comply with the summary plan description requirements under **ERISA** for all **Employee Benefit Plans**? Yes No
 - (c) Do all employee pension benefit plans or pension plans have a written investment policy? Yes No
 - (d) Are all employee pension benefit plan or pension plan assets managed by a third party investment manager? Yes No
 - (e) Do the fiduciaries review the investment guidelines used by the investment managers at least annually? Yes No
 - (f) Is the "fair market value" of all employee pension benefit plan or pension plan assets calculated at least annually? Yes No
24. During the last 5 years, has there been, or is there currently, any investigation by the IRS, Department of Labor ("DOL"), Pension Benefit Guarantee Corporation ("PBGC"), or any other state or federal agency of any **Employee Benefit Plan** or any current or former fiduciary of such **Employee Benefit Plan**? If "Yes", provide details by attachment. Yes No
25. During the last 5 years, has any **Insured** been named as a party in any civil or criminal action, administrative, arbitration, regulatory or investigative proceeding, or received any other written demands for money or services that would be within the scope of this proposed insurance? Yes No

IF "YES" TO ANY PART OF QUESTION 25., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

(a) Date Claim first made	(b) Claimant's Name	(c) Allegation	(d) Current Status
(e) Demand Amount	(f) Settlement (Indemnity) or Reserve Amount	(g) Attorney's fees	

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTION 25.

Documents Required (The following information must be submitted with the completed Proposal Form).

- Provide details to all "Yes" answers, when applicable below, or by attachment when additional space is required.
- If requesting the Fiduciary Liability Insurance Coverage Section, a copy of the most recent public accountant's audit report or IRS Form 5500 for each **Employee Benefit Plan** is required.

Please Read Carefully

The undersigned, acting on behalf of all proposed **Insureds**, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each **Insured** proposed for this insurance to facilitate the proper and accurate completion of this Proposal Form.

The undersigned agree that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and that they are material and are the basis of the insurance contract. The undersigned further agree that the Proposal Form and any material submitted herewith shall be considered attached to and a part of the **Policy**. Any material submitted with the Proposal Form shall be maintained on file (either electronically or paper) with the **Insurer** and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the **Policy** inception date, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any **Policy**, if issued, will be in reliance upon the truth of such representations; provided, however, with respect to such statements and representations, no knowledge or information possessed by any **Insureds** shall be imputed to any other **Insureds**. If any person or persons knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons. However, if the Chairperson of the Board of Directors, President, Chief Executive Officer, or Executive Director of the **Insured Entity** knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons and the **Insured Entity**;
- this Proposal Form has been completed as respects the entire **Insured Entity**;
- and the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

Dated

Chairperson of the Board of Directors, President, Chief Executive Officer or Executive Director (Signature)

Title

Chairperson of the Board of Directors, President, Chief Executive Officer or Executive Director (Print Name)

This Carolina Casualty Insurance Company Proposal Form, including any material submitted herewith, shall be held in strictest confidence.

A POLICY CANNOT BE ISSUED UNLESS THE PROPOSAL FORM IS PROPERLY SIGNED AND DATED.

Please submit this Proposal Form including appropriate documentation to:

Monitor Liability Managers, LLC, 2850 West Golf Road, Suite 800, Rolling Meadows, IL 60008-4039

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 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

NOTICE TO NEW MEXICO, 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 APPLICANTS OF KENTUCKY: 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 APPLICANTS OF MINNESOTA, NEW JERSEY, AND OKLAHOMA: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO MAINE, MASSACHUSETTS, 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 COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

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 APPLICANTS OF FLORIDA: 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.

NOTICE TO ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MARYLAND, AND RHODE ISLAND 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 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.