

Admiral Insurance Company

Nonprofit Management Liability Insurance Application

CLAIMS MADE NOTICE FOR APPLICATION: THIS APPLICATION IS FOR A CLAIMS MADE POLICY, RELATING TO CLAIMS MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.

Whenever printed in this Application, the terms in boldface type shall have the same meanings as indicated in the **Policy**. This Application 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**. Additional space for responses is provided on the last page of the application.

Named Insured

Street Address

Suite

City

County

State

Zip Code

Website Address (if applicable)

Federal Employer Identification Number (FEIN)

The Officer 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

Current Insurance Information

1. Provide the following information regarding the **Insured Entity's** most recent insurance policies. If "None", check box. None

Type of Policy	Insurance Carrier	Expiration Date	Limit of Liability	Deductible	Premium
Directors and Officers Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Employment Practices Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Fiduciary Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____

2. Within the last 5 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 5 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? Yes No
(NOT APPLICABLE IN MISSOURI)

Prior Knowledge Information

The following question pertains to: New Applicant or Increased Limit of Liability: \$ _____

4. Is any **Insured** aware of any fact, circumstance or situation involving any **Insureds** that might reasonably be expected to result in a Claim as defined in each **Coverage Section** applied for? Yes No

IF "YES" TO QUESTION 4, PROVIDE FULL DETAILS.

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.

Loss History Information

5. During the last 5 years, has any **Insured**, including any **Subsidiary**, 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, regulatory investigation or proceeding, including both domestic or foreign equivalents, involving:
- (a) any current or former employee or third party alleging discrimination, harassment, wrongful discharge and/or any wrongful employment act? Yes No
- (b) the Equal Employment Opportunity Commission or any similar state or local agency? Yes No
- (c) the U.S. Department of Labor or any similar state or local agency, alleging violations of any wage and hour law, including but not limited to, the Fair Labor Standards Act? Yes No
- (d) any government agency such as the Labor Department or fair employment agency? Yes No
- (e) the U.S. Immigration and Customs Enforcement Agency? Yes No
- (f) the National Labor Relations Board? Yes No
- (g) any investigation by the Internal Revenue Service, Department of Labor, Pension Benefit Guarantee Corporation, or any other local, state or federal agency? Yes No
- (h) any intellectual property disputes, including Copyright, Patent, or Trademark Laws? Yes No
- (i) any Anti-Trust or Fair Trade Law? Yes No
- (j) the Foreign Corrupt Practices Act? Yes No
- (k) the Office of Federal Contract Compliance Programs? Yes No
- (l) any current or former employee or any third party alleging breach of any oral or written contract? Yes No
6. During the last 5 years, has any **Insured**, including any **Subsidiary** been involved in any lawsuit not disclosed above? Yes No

IF "YES" TO QUESTIONS 5 OR 6, COMPLETE THE CLAIM / INCIDENT SUPPLEMENT.

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 5 OR 6 OF THIS SECTION.

General Information

7. The **Named Insured** has been in continuous operation since: _____
8. (a) Does the **Insured Entity** currently have a tax-exempt status under the U.S. Internal Revenue Service Code? Yes No
- If "Yes", indicate IRSC Section? 501 c 3 501 c 6 other 501 c _____
- 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
9. (a) Describe the **Insured Entity's** nature of operations: _____
- (b) Has the **Insured Entity** entered into any new areas of business within the last 12 months? Yes No
- If "Yes" describe: _____
10. Provide the following financial information with respect to the **Insured Entity**: Period Ending: _____ / _____ / _____
- Assets: \$ _____ Net Assets:* \$ _____ Annual Revenues: \$ _____
- *Net Assets equals Total Assets minus Total Liabilities

11. Does the **Insured Entity** have any **Subsidiaries** or related organizations? Yes No

If "Yes", provide the following information on all Subsidiaries or related organizations of the **Insured Entity**.

<u>Subsidiary or Organization Name</u>	<u>Nature of Business</u>	<u>Not For Profit?</u>	<u>Total Assets</u>	<u>Is coverage requested for 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 11 UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED.

12. Is the **Insured Entity** currently in bankruptcy? Yes No

13. Within the next 12 months:

(a) is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code? Yes No

(b) does the **Insured Entity** anticipate any plant, facility, branch or office closings, or layoffs? Yes No

(c) does the **Insured Entity** anticipate any consolidation, divestment, acquisition, tender offer or merger? Yes No

14. Within the last 12 months has there been any change (resignations, departures, retirements, etc.) in the position of the Chairman of the Board, President, Chief Executive Officer, Chief Financial Officer or Managing Partner (or equivalent position) that fall outside the scope of annual elections or bylaws? Yes No

IF "YES" TO ANY PART OF QUESTIONS 13 AND 14, PROVIDE FULL DETAILS,

Directors, Officers and Organization Liability Insurance Coverage Section

15 Does the **Insured Entity** own or hold any patents? Yes No

If "Yes", how many? _____

16. 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? Yes No If "Yes", provide association names below.

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

17. 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:							

18. Does the **Insured Entity** currently employ a full time Human Resources professional? Yes No

19. Indicate which formal written policies and procedures have been implemented. If "None", check box. None

Employee Handbook / Manual

I-9 Verification

Adherence to Employment "at-will" relationship with all **Employees**

Employers with more than 50 Employees

Anti-Discrimination Equal Employment Opportunity Policy

Family Medical Leave Act

Anti-Harassment Policy, including Sexual Harassment

California Employers Only

Social Media Policy

California Family Rights Act

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

20. 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 20 FOR WHICH THE ABOVE INFORMATION IS INCOMPLETE OR NOT PROVIDED.

- 21. Has any **Employee Benefit Plan** loaned or pledged any **Employee Benefit Plan** assets to any party-in-interest (including the **Insured Entity**)? Yes No If "Yes", provide full details in the space below.
- 22. Are there any overdue employer contributions for any plan, or has any plan requested or contemplated filing a request for a waiver of contributions? Yes No If "Yes", provide plan name and amount of overdue contributions below.
- 23. 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**? Yes No If "Yes", provide the details of the transaction in the space below.
- 34. If any of the following questions are answered "No", provide full details in the space below.
 - (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) Are all employee pension benefit plan or pension plan assets managed by a third party investment manager? Yes No
 - (d) Is the "fair market value" of all employee pension benefit plan or pension plan assets calculated at least annually? Yes No

Please Read Carefully

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

The undersigned agree that the statements contained in the Application are their representations, that they are material to the acceptance of the risk and the hazard assumed by the **Insurer**.

The undersigned further agree that the Application and any material submitted herewith shall be maintained on file with the **Insurer** and considered attached to and a part of the **Policy**.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Application and the **Policy** inception date, which would render this Application 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; however, with respect to such representations and statements, 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 representations and statements contained in the Application were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons;

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 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 ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, 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.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR 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 OREGON 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 MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES.

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.