
Name of Insurance Company to which application is made

**APPLICATION FOR
THE HARTFORD NON-PROFIT CHOICESM
(ALL COVERAGE PARTS – TRADE AND PROFESSIONAL ASSOCIATIONS)**



NOTICE: THE LIABILITY COVERAGE PARTS SCHEDULED IN ITEM 5 OF THE DECLARATIONS PROVIDE CLAIMS MADE COVERAGE. EXCEPT AS OTHERWISE SPECIFIED HEREIN, COVERAGE APPLIES ONLY TO A CLAIM FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND PAYMENT OF DEFENSE COSTS REDUCE THE LIMIT OF LIABILITY. NOTICE OF A CLAIM MUST BE GIVEN TO THE INSURER AS SOON AS PRACTICABLE, AFTER A NOTICE MANAGER BECOMES AWARE OF SUCH CLAIM, BUT IN NO EVENT LATER THAN SIXTY (60) CALENDAR DAYS AFTER THE TERMINATION OF THE POLICY PERIOD, OR ANY EXTENDED REPORTING PERIOD. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.

1. GENERAL INFORMATION

a) Name of Non-Profit Organization: _____

b) Address: _____

c) Nature of Operations: _____

d) Date of Incorporation: _____

e) Internet Address: _____

f) Contact person: _____

g) Email Address: _____

h) Phone: _____

i) Fax: _____

2. COVERAGE REQUESTED

Proposed Effective Date: _____

a) Liability Coverage Parts and Features Requested with desired Limit (Indicate with 'x')

Directors & Officers including Entity Coverage & Employment Practices Liability
Limit: _____

Fiduciary Liability including Settlement program Coverage
Limit: _____

b) Please indicate shared or separate limit for Liability Coverage Parts: ___ Shared ___ Separate

c) Crime

3. ORGANIZATION INFORMATION

- a) Total Revenues as of current fiscal year end: \$ _____
- b) Total Assets as of current fiscal year end: \$ _____
- c) Has the Organization experienced within the past 2 years or does the Organization expect any of the following events within the next 2 years (if "yes," please provide details - attach separate sheet if necessary):

any financial reorganization or filing for bankruptcy?	Yes	No
any downsizing, layoffs, reduction in force, or office closings ?	Yes	No
- d) Please list all Subsidiaries for which coverage is desired (attach separate sheet if necessary):

<u>NAME</u>	<u>NATURE OF BUSINESS</u>	<u>DATE CREATED OR ACQUIRED</u>	<u>%OWNED</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Most recent audited Financial Statement, Annual Report or IRS form 990, if your organization's gross annual revenues exceed \$1,000,000. Other Information deemed necessary by the Underwriter. Any other Information deemed necessary by the Underwriter.

4. DIRECTORS & OFFICERS COVERAGE PART (Complete Only if this Coverage Part is requested)

- a) Does the Organization maintain an audit committee? Yes No
- b) Does the organization maintain an investment committee? Yes No
- c) Does the Organization maintain an executive compensation committee? Yes No
- d) Is the Organization currently or has it at any time over the last year been in breach or violation of any debt covenant or loan agreement or any other material contractual obligation? Yes No
(If "yes", please attach details)
- e) Is the organization involved in any standard setting, certification or peer review activities? Yes No
(if "yes", please attach details)
- f) Does the organization have an annual or bi-annual convention or similar gathering? Yes No
- g) Are you involved in any lending, credit or collection activities? Yes No
(If "yes", please attach details)

5. EMPLOYMENT PRACTICES LIABILITY COVERAGE PART

- a) For the current and previous years, please list the following Employee information:

Year				
Full Time	_____	_____	_____	_____
Part Time/Seasonal	_____	_____	_____	_____
Involuntary Terminations:	_____	_____	_____	_____
Resignations:	_____	_____	_____	_____

- b) Does the Organization maintain and distribute an employee handbook? Yes No
- c) Does the Organization have a Human Resources Department? Yes No

Please note that Organizations with More than 100 Employees must complete a Human Resources Procedures Supplemental Application.

6. FIDUCIARY LIABILITY COVERAGE PART (Complete Only if this Coverage Part is Requested)

For Each Plan to be covered, please list the following:

PLAN NAME	PLAN TYPE*	# OF PARTICIPANTS	PLAN ASSETS (CURRENT YEAR)	PLAN STATUS**
			\$	
			\$	
			\$	

* Plan Type: Defined Benefit (DB), Defined Contribution (DC), Welfare (W), Employee Stock Ownership (ESOP) or Other (O).

** Plan Status: Active (A), Merged (M), Terminated (T) or Frozen (F).

- | | | | |
|----|---|-----|----|
| a) | Does the plan conform to ERISA? | Yes | No |
| b) | Has the Organization, any plan, or plan fiduciary been accused or found guilty of a breach of fiduciary duty or violation of ERISA? | Yes | No |
| c) | During the past 2 years have there been, or during the next year do you anticipate any reduction in benefits? | Yes | No |
| d) | Has any plan been investigated by the DOL, IRS or any other regulatory agency in the past 2 years? | Yes | No |
| e) | Has the IRS threatened to withdraw the tax-exempt status of a plan? | Yes | No |

If there is an adverse response to any question above, please provide details.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Plan Audit or Form 5500 for all Pension and Welfare plans to be covered by this policy when Plan Participants exceed 100.

7. CRIME COVERAGE PART (Complete Only if this Coverage Part is Requested. Organizations with more than 500 employees must complete a crime supplemental application)

LOSS EXPERIENCE		
List all fidelity and crime losses discovered or sustained in the last five years. Check here if none: <input type="checkbox"/>		
DATE OF LOSS	TYPE OF LOSS (Employee Dishonesty, Forgery, etc.)	AMOUNT OF LOSS

Please attach details of all losses including description, corrective action taken and amount covered by insurance.

- | | | | |
|----|--|-----|----|
| a) | Do you prohibit any employee who reconciles bank statements from also: | Yes | No |
| | - Signing checks? | Yes | No |
| | - Handling bank deposits? | Yes | No |
| | - Making withdrawals? | Yes | No |
| | - Having access to check signing machines or signature plates? | Yes | No |
| b) | Is an authorized vendor list utilized to assist in detecting payments to fictitious suppliers? | Yes | No |
| c) | For new employees, are background checks conducted? If "yes," does it include: | Yes | No |
| | - Prior employment verification? | Yes | No |
| | - Criminal history? | Yes | No |
| | - Drug testing? | Yes | No |
| | (If the answer is "No" to any of questions a) through c), please provide details.) | | |
| d) | Within the last three years has an internal or external auditor made any comments regarding internal control weaknesses or recommendations for improvements? | Yes | No |
| | (If "yes," please provide details) | | |

e) Number of locations: _____

PLEASE INDICATE:

Desired Crime Coverages	Expiring Limit	Expiring Retention	Requested Limit	Requested Retention
Employee Dishonesty / Theft (A)	\$	\$	\$	\$
Forgery or Alteration (B)	\$	\$	\$	\$
Inside the Premises (C)	\$	\$	\$	\$
Outside the Premises (D)	\$	\$	\$	\$
Computer Fraud (E)	\$	\$	\$	\$
Money Orders & Counterfeit Currency	\$50,000 (automatically included, if Crime is quoted)			

Expiring Crime Premium: _____

8. PREVIOUS INSURANCE:

Please provide the following details regarding the Organization's Current Insurance programs:

PRODUCT	INSURER	LIMIT	RETENTION	PERIOD FROM/TO	PREMIUM
D&O	_____	_____	_____	_____	_____
EPL	_____	_____	_____	_____	_____
Fiduciary	_____	_____	_____	_____	_____
Crime	_____	_____	_____	_____	_____

9. PRIOR KNOWLEDGE (HARTFORD RENEWAL APPLICANTS: Question 9. need not be answered). If "yes," provide complete details.

Does anyone for whom insurance is being applied have any knowledge or information of any error, misstatement, misleading statement, act, omission, neglect, breach of duty or other matter that may give rise to a claim that may fall within the scope of coverage of the proposed insurance? Yes No

IT IS AGREED THAT IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM BASED ON, ARISING FROM, OR IN ANY WAY RELATING TO SUCH ERROR, MISSTATEMENT, MISLEADING STATEMENT, ACT, OMISSION, NEGLIGENCE, BREACH OF DUTY OR OTHER MATTER OF WHICH THERE IS KNOWLEDGE OR INFORMATION SHALL BE EXCLUDED FROM COVERAGE UNDER THE INSURANCE BEING APPLIED FOR.

10. LOSS HISTORY (HARTFORD RENEWAL APPLICANTS: Question 10. need not be answered). If "yes," provide complete details.

a) **Within the last three years, has the applicant, its directors, officers and/or any other proposed insured person or organization received any complaint, suit, inquiry or notice of hearing from any state or federal legislative committee, regulatory body, or any other party?** Yes No

b) Has any Insurer cancelled or refused to renew any Directors and Officers, Employment Practices, Fiduciary Liability Crime/Fidelity, or similar insurance within the past 3 years?*

Yes No

* MISSOURI APPLICANTS NEED NOT REPLY to 10(b).

REGARDING QUESTIONS A, IT IS AGREED THAT IF ANY SUCH CLAIMS, DEMANDS OR NOTICES EXIST, ANY CLAIM BASED UPON, ARISING FROM OR IN ANY WAY RELATED TO SUCH MATTERS SHALL BE EXCLUDED FROM THE INSURANCE BEING APPLIED FOR. THE INFORMATION PROVIDED IN THIS APPLICATION IS FOR UNDERWRITING PURPOSES ONLY AND DOES **NOT** CONSTITUTE NOTICE TO THE COMPANY OF A CLAIM OR POTENTIAL CLAIM UNDER ANY POLICY. IF YOU INTEND TO NOTICE A CLAIM OR POTENTIAL CLAIM FOR POSSIBLE COVERAGE, PLEASE COMPLY WITH THE NOTICE OF CLAIM CONDITIONS/PROVISIONS FOUND IN YOUR POLICY, BY SENDING WRITTEN NOTICE OF SUCH TO: (Insert the address and phone number of the local The Hartford office.)

FRAUD WARNING STATEMENTS

ARKANSAS 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.

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.

DISTRICT OF COLUMBIA APPLICANTS: 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 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 OF THE THIRD DEGREE.

HAWAII APPLICANTS: FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH.

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.

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.

MAINE 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

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.

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.

NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES.

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."

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.

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 ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION OR; (2) FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT MAY BE VIOLATING STATE LAW.

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.

TENNESSEE 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.

VIRGINIA 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.

VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE, OR A STATEMENT OF CLAIM CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME IN CERTAIN JURISDICTIONS.

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."

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.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE. THE "EFFECTIVE DATE" IS THE DATE THE COVERAGE IS BOUND OR THE FIRST DAY OF THE CURRENT POLICY PERIOD, WHICHEVER IS LATER.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION MUST BE SIGNED BY THE CHAIRMAN OF THE BOARD, CHIEF EXECUTIVE OFFICER OR THE PRESIDENT OF THE ORGANIZATION.

SIGNATURE _____

TITLE: _____ DATE _____

PLEASE SUBMIT THIS PROPOSAL AND APPROPRIATE MATERIALS TO:
Program Administrator
Aon Association Services
1120 20th St, NW, Ste 600, Washington DC 20036
800-432-7465 • 800-701-1982 fax