

Berkley Insurance Company

ExecSuite®

Existing Insured Renewal Proposal Form

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 any Extended Reporting Period that may apply.

- Complete the sections of this Proposal Form for each Coverage Requested as indicated below.
- Provide details to all "Yes" answers, when applicable, by attachment whether or not prior coverage was in place.

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**

Primary Location Street Address

Suite

City

County

State

Zip Code

Website Address (if applicable)

Federal Employer Identification Number (FEIN)

Name and title of the officer of the **Named Insured** designated to receive any and all notices from the **Insurer**.

E-mail Address

Telephone Number

Fax Number

The contact information provided will be used for internal purposes and will not be sold to any third party.

The mailing address is the same as the primary location. If not, provide mailing address:

Mailing Street Address

Suite

City

State

Zip Code

General Information

1. Provide the following financial information with respect to the **Insured Entity**:

Assets (000):	\$	Annual Revenues (000):	\$	Cash:	\$
Equity (000):	\$	Net Income / Loss (000):	\$	Period Ending:	/ /

IF "YES" TO ANY PART OF QUESTIONS 2. THROUGH 4. OF THIS SECTION, PROVIDE DETAILS BY ATTACHMENT.

2. Has the **Insured Entity** entered into any new areas of business within the last 12 months? Yes No
3. Is the **Insured Entity** currently in bankruptcy? Yes No
4. Answer each of the following questions with respect to the **Insured Entity's** recent 12-month history and expectations for the next 12 months:
- | | <u>Last 12 months</u> | <u>Next 12 months</u> |
|--|--|--|
| (a) filing a petition for protection under the bankruptcy code? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) 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)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) raised or raising funds by any venture capital, private placement or private offering of any equity or debt securities? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (d) any public sale of equity or debt securities and/or the filing of any registration statement or similar disclosure for an offering or sale of securities? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (e) any plant, facility, branch or office closings, or layoffs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (f) any consolidation, divestment, acquisition, tender offer or merger? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (g) suspension by the secretary of state or state agency for failure to pay taxes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (h) violation of any debt or loan covenants? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- (i) has there been any changes to the **Insured Entity's** nature of operations or primary Standard Industrial Classification ("SIC") Code, not previously reported to the **Insurer**? Yes No Yes No
- (j) has there been any changes to the locations and/or **Subsidiaries** of the **Insured Entity**, not previously reported to the **Insurer**? Yes No Yes No
- (k) has there been any changes to the employee welfare benefit plans, employee pension benefit plans or pension plans, as defined by ERISA, (hereinafter referred to as **Employee Benefit Plans**) which the **Insured Entity** maintains or to which it contributes, not previously reported to the **Insurer**? Yes No Yes No
5. Within the last 12 months, has there been any change in the status of any claims, losses or circumstances reported in any application previously submitted to the **Insurer**? Yes No

IF "YES" TO QUESTION 5. PROVIDE FULL DETAILS OF ANY CHANGES IN STATUS FOR ANY CLAIMS, LOSSES OR CIRCUMSTANCES, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION 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 (h) Remedial Action Taken

Directors, Officers and Corporate Liability Section

- Complete the Directors, Officers and Corporate Liability section of the Proposal Form only if requesting this coverage.
- Provide a copy of the most recent interim and annual financial statements (audited, if available).
- List of Board of Directors and Senior Executive Officers, including external affiliations.

6. (a) Total number of shares or units outstanding: _____
 (b) Total shareholders, unit holders, or members of record: _____
7. List all shareholders, unit holders or members with 10% or more interest in the **Named Insured** and/or the **Insured Entity**:

Name	Percent Ownership	Director/Officer	Family*
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Is the shareholder listed related by family to another shareholder, director or officer of any **Insured Entity**.

Employment Practices Liability Section

- Complete the Employment Practices Liability section of the Proposal Form only if requesting this coverage.

8. Complete the table:

	Current Year	Previous Year
(a) Total number of full-time employees in the U.S.:		
(b) Total number of part-time employees in the U.S.:		
(c) Total number of independent contractors in the U. S.:		
(d) Total number of leased, seasonal, temporary, volunteers and interns in the U.S.:		
(e) Regarding the above totals, number of employees located in California:		
(f) Total number of employees located outside the U.S.:		

Fiduciary Liability Section

- Complete the Fiduciary Liability section of the Proposal Form only if requesting this coverage.

9. 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.

Name of Plan	Type of Plan*	Name of Plan Sponsor	Number of Plan Participants	Fair Market Value of Plan Assets (000's)
				\$
				\$
				\$

*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

10. 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

Producer Information

Submitted by (Agency Name)

Dated

Agent's Name (Individual's Name)

Agent's License Number

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 information submitted herewith are their material representations 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 **Insured Person** shall be imputed to any other **Insured Person**. 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, and such statements materially affect either the acceptance of the risk or the hazard assumed by the **Insurer** under this **Policy**, then this **Policy** shall not apply as to that person or persons. However, if the President, Chief Executive Officer, Chief Financial Officer or Managing Partner 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, and such statements materially affect either the acceptance of the risk or the hazard assumed by the **Insurer** under this **Policy**, then this **Policy** shall not apply as to that person or persons and the **Insured Entity**;
- the information contained in this Proposal Form shall not be used by the **Insureds** as notice as provided for in section VII. of the Common Policy Terms and Conditions Section of this **Policy**;
- this Proposal Form has been completed as respects the entire **Insured Entity**;
- the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

Dated

President, Chief Executive Officer, Chief Financial Officer, or Managing Partner (Signature)

President, Chief Executive Officer, Chief Financial Officer, or Managing Partner (Print Name)

Title

Dated

Human Resources Manager, or equivalent position (Signature)

This Admiral 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, 233 S. Wacker Drive, Suite 3900
Chicago, IL 60606

Berkley Insurance Company

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.