



Return application to:
 CB Malaga Insurance Services LLC
 tel: 877-245-5887
 fax: 805-426-8540
 email: info@cbspecialty.com

Travelers Casualty and Surety Company of America

CyberRisk Short Form Application

Claims-Made: The information requested in this Application is for a Claims-Made policy. If issued, the policy will apply only to claims first made during the policy period, or any applicable extended reporting period.

Defense Within Limits: The limit of liability available to pay losses will be reduced and may be completely exhausted by amounts paid as defense costs.

IMPORTANT INSTRUCTIONS

This Application will only be accepted for Applicants with revenues of \$50,000,000 or less **and** assets of \$500,000,000 or less.

Under this CyberRisk Coverage, affiliates, other than Subsidiaries as defined in this coverage, are not covered unless the Insurer has agreed specifically to schedule such entities by endorsement.

GENERAL INFORMATION

Name of Applicant:

Street Address:

City: State: Zip:

Applicant website: Year Established: NAICS Code:

Total assets as of most recent fiscal year-end: Annual revenues as of most recent fiscal year-end:
 \$ \$

Entity type (select all that apply):

- Private
- Nonprofit
- Financial Institution
- Publicly Traded
- Franchisor or Franchisee
- Homeowner or Condo Association

UNDERWRITING INFORMATION

1. Indicate whether the Applicant has:
 - a. Up-to-date, active firewall technology Yes No
 - b. Up-to-date, active anti-virus software on all computers, networks, and mobile devices Yes No
 - c. A process in place to regularly download and install patches Yes No
 - d. Backup and recovery procedures in place for all important business and customer data Yes No
 - e. An incident response plan to respond to a network intrusion Yes No
 - f. A disaster recovery plan, business continuity plan, or equivalent to respond to a computer system disruption Yes No
 - g. Controls to ensure the content of media communications and websites are lawful Yes No
 - h. Procedures in place which require service providers with access to the Applicant's systems or the Applicant's confidential information to demonstrate adequate network security controls Yes No
 - i. Multi-factor authentication for remote access to email and other systems and programs that contain private or sensitive data in bulk Yes No N/A
2. Is the Applicant currently compliant with Payment Card Industry Data Security Standards (PCI-DSS)? Yes No N/A
3. Is the Applicant HIPAA compliant? Yes No N/A
4. Indicate whether the Applicant encrypts private or sensitive data:
 - a. While at rest in the Applicant's database or on the Applicant's network Yes No N/A
 - b. While in transit in electronic form Yes No N/A
 - c. While on mobile devices Yes No N/A
 - d. While on employee owned devices Yes No N/A
 - e. While in the care, custody, and control of a third party service provider Yes No N/A

LOSS INFORMATION

5. In the past three years, has the Applicant:
- a. Experienced: (1) a network or computer system disruption due to an intentional attack or system failure; (2) an actual or suspected data breach; or (3) a cyber extortion demand? Yes No
- b. Received any complaints, claims, or been subject to any litigation involving: Matters of data protection law, intellectual property rights, defamation, rights of privacy, identity theft, denial of service attacks, computer virus infections, theft of information, damage to third party networks, or access to the Applicant's network? Yes No
6. Is the Applicant, any Subsidiary, or any person proposed for this insurance aware of any circumstance that could give rise to a claim against them under this CyberRisk coverage? Yes No

If the Applicant answered Yes to any part of Question 5 or Question 6, attach details of each claim, complaint, allegation, or incident, including costs, losses, or damages incurred or paid, any corrective procedures to avoid such allegations in the future, and any amounts paid as loss under any insurance policy.

REQUESTED INSURANCE TERMS

7. Requested Terms:
- Aggregate Limit Requested: \$ _____
- Retention Requested: \$ _____
- Effective Date Requested: _____
8. Does the Applicant currently purchase CyberRisk coverage? Yes No
- If Yes, provide the following:*
- Expiring Carrier: _____
- Expiring Limit: \$ _____
- Date coverage first purchased? _____

ORGANIZATIONS NOT ELIGIBLE FOR COVERAGE

Coverage will not be considered for companies involved in whole or in part with paramilitary operations, pornography, adult entertainment, escort services, prostitution, or the manufacturing, distribution, or sale of marijuana.

NOTICE REGARDING COMPENSATION

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Agency Compensation, One Tower Square, Hartford, CT 06183.

FRAUD STATEMENTS – ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company to defraud or attempt 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 policyholder or claimant to defraud or attempt to defraud the policyholder or claimant regarding a settlement or award payable from insurance proceeds will be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO, AND PENNSYLVANIA: 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. (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company to defraud the company. Penalties include imprisonment, fines, and denial of insurance benefits.

OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

PUERTO RICO: Any person who knowingly and intending to defraud presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, will incur a felony and, upon conviction, will be sanctioned for each violation with the penalty of a fine of not less than \$5,000 and not over \$10,000, or a fixed term of imprisonment for three years, or both penalties. Should aggravating circumstances be present, the penalty established may be increased to a maximum of five years; if extenuating circumstances are present, it may be reduced to a minimum of two years.

SIGNATURES

The undersigned Authorized Representative represents that to the best of his or her knowledge and belief, and after reasonable inquiry, the statements provided in response to this Application are true and complete, and, except in NC, may be relied upon by Travelers as the basis for providing insurance. The Applicant will notify Travelers of any material changes to the information provided.

Electronic Signature and Acceptance – Authorized Representative*

*If electronically submitting this document, electronically sign this form by checking the Electronic Signature and Acceptance box above. By doing so, the Applicant agrees that use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes acceptance and agreement as if signed in writing and has the same force and effect as a signature affixed by hand.

Authorized Representative Signature: X	Authorized Representative Name, Title, and email address:	Date (month/dd/yyyy):
Producer Name (required in FL & IA): X	State Producer License No (required in FL):	Date (month/dd/yyyy):
Agency:	Agency contact and email address:	Agency Phone Number:

ADDITIONAL INFORMATION
