TRAVELERS

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

Executive Choice+®
Fiduciary Liability Coverage Application

Travelers Casualty and Surety Company of America

NOTICE

ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST INSUREDS DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED BY THE AMOUNTS INCURRED AS DEFENSE EXPENSES, AND DEFENSE EXPENSES WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY CLAIM UNLESS DUTY–TO-DEFEND COVERAGE IS SPECIFICALLY PROVIDED.

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

I. GENERAL INFORMATION

1. **Applicant** Information:

   Name of **Applicant**: _____

   Street Address: _____

   City, State, ZIP Code: _____

   Year **Applicant's** business was established: _____

   Description of **Applicant's** operation: _____

2. **Applicant's** Standard Industrial Classification (SIC) code, if known (4-digit number): _____

II. ORGANIZATION INFORMATION

1. In the next 12 months (or during the past 24 months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) the following:

   a. Any actual or proposed merger, acquisition, or divestiture? Yes ☐ No ☐

   b. Any branch, location, facility, office, or subsidiary closings, consolidations or layoffs? Yes ☐ No ☐

   If either of the questions above were answered Yes, please attach an explanation, including the timing, the essential terms of the event, arrangement, and the surrounding circumstances.

III. EMPLOYEE INFORMATION

1. Maximum number of employees at any one point during the previous 12 months for the following classifications (regardless of whether they are full or part time):

Total Employees (Including leased, union, independent contractors and temporary employees)	Leased	Labor Unions	Independent Contractors	Temporary

IV. PLAN DATA

1. Premium to be paid by: Employer: ☐ Trust or Plan: ☐

2. Complete the chart for all plans for which coverage is requested:

Full Plan Name	*Plan Type	Current Asset Value	Latest FYE Annual Contributions	Current # of Participants	**Plan Status
		$	$		
		$	$		
		$	$		
		$	$		
		$	$		

***Plan Types:** **Defined Benefit (DB) Defined Contributions (DC) ESOP (E) Self-Funded Welfare Benefit Plan (W) Other (O) – Attach Explanation**

****Plan Status:** **Active (A) Frozen (F) Sold (S) Terminated (T) (If any plan has been terminated, indicate date of transaction)**

List any additional plans on a separate attachment.

V. PLAN UNDERWRITING QUESTIONS

1. Is each plan reviewed periodically to assure there are no violations of ERISA (e.g., prohibited transactions or party-in-interest rules)? Yes ☐ No ☐
   If No, please attach an explanation.

2. Does any plan (a) not conform to the standards of eligibility, participation, vesting, blackout notification requirements and other provisions of ERISA or similar foreign law; or (b) hold employer securities or employer real property in violation of ERISA or in excess of ERISA limits? Yes ☐ No ☐
   If Yes, please attach an explanation.

3. Has any plan (a) been the subject of an investigation by the DOL, IRS, or any similar foreign agency; (b) had its tax exempt status withdrawn or threatened to be withdrawn by the IRS; (c) filed for an exemption from a prohibited transaction; or (d) received an adverse opinion as to its financial condition by an independent public accountant? Yes ☐ No ☐
   If Yes, please attach an explanation.

4. If any plan is a defined benefit plan, has such plan (a) experienced an event reportable to the PBGC; (b) not been certified by an actuary to be adequately funded in accordance with ERISA's minimum funding standard; or (c) been converted into a cash balance plan or is any such conversion expected in the next 12 months? If there are no defined benefit plans, please check "N/A". N/A ☐ Yes ☐ No ☐
   If Yes, please attach an explanation.

5. Has any plan (a) been amended within the last 12 months in a way that will result in the reduction of benefits or are any such amendments anticipated within the next 12 months; or (b) been merged with another plan, terminated or sold within the past 2 years or is any such merger, termination or sale anticipated in the next 12 months? Yes ☐ No ☐
   If Yes, please attach an explanation detailing the implementation, disclosure and any relevant blackout periods.

6. Are there any outstanding or delinquent plan contributions or plan loans, leases or debt obligations that are in default or classified as uncollectible? Yes ☐ No ☐
   If Yes, please attach an explanation.

7. Does the employer, committee or employer representatives, or union board of trustees have final say over the determination of whether benefits will be paid under any healthcare plan sponsored by the **Applicant**? Yes ☐ No ☐
   If Yes, please identify the names of such plans in a separate attachment.

8. Does any plan invest in a mutual fund, collective trust or similar investment pool that receives investment management services from the **Applicant** for a fee? Yes ☐ No ☐
   If Yes, please attach an explanation.

9. Please provide name of firm(s) providing the following services:

CPA	Attorney	Actuary	Investment Advisor

VI. EMPLOYER SECURITIES

*Please complete this section only if the **Applicant** sponsors an ESOP or a defined contribution plan that invests in employer securities.*

1. Name of plan(s) holding employer securities:

   _____

   _____

2. As a matter of plan design, is company stock required to be offered as an investment alternative? Yes ☐ No ☐

3. If the plan is an ESOP, is it leveraged? N/A ☐ Yes ☐ No ☐
   If Yes, provide the date, terms and reasons for loan as well as the names of any parties selling shares to the ESOP and list any guarantors of the loan.

   _____

   _____

4. Does an independent trustee or other fiduciary not otherwise affiliated with the **Applicant** monitor the plan's stock holdings? Yes ☐ No ☐
   If Yes, provide the name of all independent trustees or other fiduciaries.

5. Does the plan allow immediate diversification of contributions made in company stock? Yes ☐ No ☐
   If No, please describe if and when diversification is allowed.

6. Does the plan include a provision for pass-through voting and tendering of allocated employer securities held by the plan and "mirrored" voting and tendering of unallocated employer securities held by the plan? Yes ☐ No ☐
   If No, please provide an explanation.

7. Does the plan have percentage caps on the amount of an employee's plan account that can be invested in company stock? Yes ☐ No ☐
   If Yes, please provide the percentage amount: _____ %

VII. CURRENT INSURANCE INFORMATION/REQUESTED INSURANCE TERMS

Requested Limit (A)	Requested Retention (B)	Requested Effective Date (C)	Coverage Currently Purchased (D)
$	$		Yes ☐ No ☐

Expiring Limit (E)	Expiring Retention (F)	Expiring Premium (G)	Current Insurer (H)	Date Coverage First Purchased (I)
$	$	$		

1. What is the **Applicant's** preference for defense coverage? Duty to Defend ☐ Reimbursement ☐

2. If Liability Coverage is currently purchased as indicated in Column (D) above, but has been in place for less than 3 years, please answer the following question:

   As of the date the **Applicant** first purchased the Liability Coverage, is the **Applicant** or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim being made against them under the Liability Coverage for which the **Applicant** is applying? Yes ☐ No ☐
   If Yes, please attach an explanation.

3. If Liability Coverage is not currently purchased as indicated in Column (D) above, please answer the following question:

   Is the **Applicant** or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under the Liability Coverage for which the **Applicant** is applying? Yes ☐ No ☐
   If Yes, please attach an explanation.

4. If the Requested Limit in Column (A) exceeds the Expiring Limit in Column (E), please answer the following question:

   Solely with respect to any higher limits requested or that may ultimately be issued for the proposed insurance, is the **Applicant** or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under the Liability Coverage for which the **Applicant** is applying? Yes ☐ No ☐
   If Yes, please attach an explanation.

*With respect to the information required to be disclosed in response to the questions above, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of the **Applicant** had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy*.

VIII. LOSS INFORMATION

1. In the past 3 years, whether or not insured, has any plan, **Applicant**, or person proposed for this insurance been accused or found guilty of any criminal act or been accused of, found guilty of or held liable for a breach of fiduciary duty, or a violation of ERISA, or any similar state, local or foreign law or have any ERISA-related claims, administrative or regulatory proceedings, charges, hearings or demands been made? Yes ☐ No ☐
   If Yes, please complete the table below:

Date of Such Claim	Nature of Claim	Amount Paid for Defense	Amount Sought or Paid for Damages	Covered by Insurance?	Corrective Procedures Implemented	Current Status
		$	$	Yes ☐ No ☐		
		$	$	Yes ☐ No ☐		

To enter more information, please attach a separate page to the Application.

IX. REQUIRED ATTACHMENTS

As part of this Application, please submit the following documents (*these documents, and the representations and facts they contain, are made a part of this Application, whether such documents are physically delivered to the Company by the **Applicant** or are obtained by the Company from any public source, including the Internet*):

- Most recent annual financial statement of the **Applicant**
- Plan financial statements for defined benefit plans and self insured welfare plans, if limit requested is greater than $1,000,000
- Plan financial statements for each defined contribution plan, if limit requested is greater than $5,000,000 and/or the plan invests in employer securities
- Most recent 5500 of all plans

X. COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

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, Enterprise Development, One Tower Square, Hartford, CT 06183.

XI. FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., 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.

Attention: Insureds in Colorado
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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

Attention: Insureds in 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.

Attention: Insureds in 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.)

Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and Washington
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.

Attention: Insureds in 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.

Attention: Insureds in Puerto Rico
Any person who knowingly and with the intention of defrauding 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, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

XII. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PARTNER, PRINCIPAL, TRUSTEE OR OTHER OFFICER ACCEPTABLE TO TRAVELERS) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Signature* of **Applicant's** Authorized Representative (Partner, Principal, Trustee or Officer)	Name (Printed)
Title	Date

***IF YOU ARE ELECTRONICALLY SUBMITTING THIS APPLICATION TO TRAVELERS, APPLY YOUR ELECTRONIC SIGNATURE TO THIS FORM BY CHECKING THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX BELOW. BY DOING SO, YOU HEREBY CONSENT AND AGREE THAT YOUR USE OF A KEY PAD, MOUSE, OR OTHER DEVICE TO CHECK THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX CONSTITUTES YOUR SIGNATURE, ACCEPTANCE, AND AGREEMENT AS IF ACTUALLY SIGNED BY YOU IN WRITING AND HAS THE SAME FORCE AND EFFECT AS A SIGNATURE AFFIXED BY HAND.**

AUTHORIZED REPRESENTATIVE'S ELECTRONIC SIGNATURE AND ACCEPTANCE ☐

XIII. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE):

Producer Signature	Producer Name (Printed)	
Agency Name	Agency Code	License Number