TRAVELERS

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

Wrap+®
Private Partnership
Multi-Coverage Application

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.

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

A. COMMON SECTION

I. GENERAL INFORMATION

1. **Applicant** Information:

   Name of **Applicant**: _____

   Street Address: _____

   City, State, ZIP Code: _____

   Website Address: _____

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

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

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

3. Is the **Applicant** a subsidiary of a foreign parent? Yes ☐ No ☐

4. Does the **Applicant** currently file, or does it anticipate filing in the next 6 months, any documents with the Securities and Exchange Commission or similar foreign authority regarding any equity or debt securities? Yes ☐ No ☐

II. ORGANIZATION INFORMATION

1. List and describe all entities in which the **Applicant's** ownership interest is 50% or greater or over which the **Applicant** has management control *(Check here if not applicable* ☐*)*. If individuals or entities other than the **Applicant** have an ownership interest in such entities of 5% or greater, please provide such information as indicated:

Name	% Owned By Applicant	Year Started	Description Of Operations	Entity Type*	Individuals or Entities with at Least 5% Ownership Interest (Do Not Include Applicant)	% Owned
	%					%
	%					%
	%					%
	%					%

***Entity Type: FP=For-Profit (other than Partnership); NP=Non-Profit; GP=General Partnership; LP=Limited Partnership; LLC=Limited Liability Company**

To enter more information, please attach a separate page or an organization chart with ownership detail.

2. 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 creation of a new business, subsidiary, or division? Yes ☐ No ☐

   c. Any registration for a public offering or a private placement of securities? Yes ☐ No ☐

   d. Any reorganization or arrangement with creditors under federal or state law? Yes ☐ No ☐

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

   If any of the questions above were answered Yes, please attach an explanation, including the timing, the essential terms of the event, arrangement, impact on employee base and the surrounding circumstances.

III. PARTNERSHIP INFORMATION

*Please attach information to explain the nature of the business of the **Applicant**, including brochures, pamphlets, newsletters, etc.*

1. Principal Partnership Entity: _____

2. Please designate whether the principal partnership applying for this insurance is a general partnership or a limited partnership: General Partnership ☐ Limited Partnership ☐

3. If a limited partnership, please list the general partner(s) for such limited partnership:

   _____

   _____

4. List all additional partnerships for which insurance coverage is being applied for in this Application:

Name	Date Acquired (A) Or Created (C)	General Partner(s)	Description of Operations	# of Limited Partners	Individuals or Entities with at Least 5% Ownership Interest	% Owned
						%
						%
						%
						%
						%

To enter more information, please attach a separate page or an organization chart with ownership detail.

5. List all general partners (including the **Applicant**) for which insurance coverage is being applied for in this Application:

Name of General Partner(s) (Individual or Entity)	Individuals or Entity(ies) (Other than Applicant) with at Least 5% Ownership Interest in Entity General Partner	% Owned
		%
		%
		%
		%
		%

To enter more information, please attach a separate page or an organization chart with ownership detail.

6. Is any owner of any entity applying for this insurance a trust that qualifies as an Employee Stock Ownership Plan under ERISA or holds securities for the benefit of employees? Yes ☐ No ☐
   If Yes, please attach most recent stock valuation report.

7. Have there been any changes in the Board of Managers or Senior Management of the **Applicant** within the past 3 years for reasons other than death or retirement? Yes ☐ No ☐
   If Yes, please attach full details.

8. Has the general partner for any partnership entity applying for this insurance changed within the past 3 years? Yes ☐ No ☐
   If Yes, please attach full details.

9. Are there currently any outstanding loans to any Director, Officer, natural-person general partner, member of the Board or Managers or functional equivalent of the **Applicant**? Yes ☐ No ☐
If Yes, please attach full details.

IV. EMPLOYEE INFORMATION

1. Total number of employees*: _____
2. Total number of employees* outside the U.S.? _____
3. Total number of locations: _____
4. Complete the following chart providing the number of Full Time and Part Time employees*, Volunteers and natural person Independent Contractors:

As of Date of Application		Previous 12 Months		As of Date of Application	
Full Time Employees	**Part Time Employees**	**Full Time Employees**	**Part Time Employees**	**Volunteers**	**Independent Contractors**

**Full and part time including leased, seasonal, and temporary employees*

V. AUDITOR INFORMATION

1. Scope of financial statement preparation:
   Internal ☐ CPA Compilation ☐ CPA Review ☐ CPA Audit ☐ None ☐
2. Has the **Applicant** changed outside auditors in the last 3 years? N/A ☐ Yes ☐ No ☐
   If Yes, please attach an explanation.
3. Have the outside auditors stated there are material weaknesses in the **Applicant's** systems of internal controls? N/A ☐ Yes ☐ No ☐
   If Yes, please attach an explanation and provide the latest CPA letter to management and management's response.
4. Has the **Applicant** implemented all material recommendations of the auditor? N/A ☐ Yes ☐ No ☐
   If No, please attach an explanation.
5. Has any auditor issued a "going concern" opinion for the **Applicant's** financial statements during the past 3 years? N/A ☐ Yes ☐ No ☐
   If Yes, please attach an explanation.

VI. CURRENT INSURANCE INFORMATION/REQUESTED INSURANCE TERMS

LIABILITY COVERAGES

Requested Liability Coverage	Requested Coverage (A)	Requested Limit (B)	Requested Retention (C)	Coverage Currently Purchased (D)	Expiring Limit (E)	Expiring Retention (F)	Expiring Premium (G)
Private Partnership Liability	Yes ☐ No ☐	$	$	Yes ☐ No ☐	$	$	$
	Requested Effective Date:		Current Insurer:			Date Coverage First Purchased:	
Employment Practices Liability	Yes ☐ No ☐	$	$	Yes ☐ No ☐	$	$	$
	Requested Effective Date:		Current Insurer:			Date Coverage First Purchased:	
Fiduciary Liability	Yes ☐ No ☐	$	$	Yes ☐ No ☐	$	$	$
	Requested Effective Date:		Current Insurer:			Date Coverage First Purchased:	

1. Policy Options:
   a. What is the **Applicant's** preference for defense coverage? Duty to Defend ☐ Reimbursement ☐
   b. What is the **Applicant's** preference for Liability Coverage limits: Individual Limits ☐ Shared Limits ☐

c. If the **Applicant** is requesting Employment Practices Liability coverage as indicated in Column (A) above, is this coverage also requested for Third Party Claims? Yes ☐ No ☐

*If **Applicant** is requesting such Third Party Claim coverage, but does not currently purchase such coverage, please answer Question 3 below.*

2. Solely with respect to those Liability Coverage(s) currently purchased as indicated in Column (D) above which have been in place for less than 3 years, please answer the following question:

   As of the date the **Applicant** first purchased the Liability Coverage(s), 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(s) for which the **Applicant** is applying? Yes ☐ No ☐
   If Yes, please attach an explanation.

3. With respect to Liability Coverage(s) 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(s) for which the **Applicant** is applying? Yes ☐ No ☐
   If Yes, please attach an explanation.

4. With respect to the Liability Coverage(s) being applied for above, if the Requested Limit in Column (B) 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*.

CRIME, KIDNAP AND RANSOM AND IDENTITY FRAUD EXPENSE REIMBURSEMENT COVERAGES

1. Requested Crime Coverage	Requested Limit	Requested Retention
Fidelity: Employee Theft	$	$
Fidelity: ERISA Fidelity	$	$
Fidelity: Employee Theft of Client Property	$	$
Forgery or Alteration	$	$
On Premises (Money, Securities and Other Property)	$	$
In Transit (Money, Securities and Other Property)	$	$
Money Orders and Counterfeit Money	$	$
Computer Crime	$	$
Funds Transfer Fraud	$	$
Personal Accounts Protection	$	$
Claim Expense	$	$

Requested effective date: _____

Expiring insurer: _____ Expiring premium: $_____

2. Requested Kidnap and Ransom Coverage	Effective Date	Requested Limit	Requested Retention
Yes ☐ No ☐		$	$

Expiring insurer: _____ Expiring premium: $_____

3. Requested Identity Fraud Expense Reimbursement Coverage	Effective Date	Requested Limit				Requested Retention			
Yes ☐ No ☐		$ 1,000 ☐		$10,000 ☐		$ 0 ☐		$250 ☐	
		$ 5,000 ☐		$25,000 ☐		$100 ☐			

Expiring insurer: _____ Expiring premium: $_____

VII. LOSS INFORMATION

LIABILITY COVERAGES

1. With respect to the Liability Coverages requested in this Application, has any person or entity proposed for this insurance been a party to, or subject of, any administrative or regulatory proceedings or civil or criminal charges, hearings, demands, or lawsuits during the past 3 years, whether or not insured, including any such matter involving securities, security holders, creditors, partnership, antitrust or fair trade law, copyright or patent law, ERISA, discrimination, harassment or employment-related matters? 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.

CRIME AND KIDNAP AND RANSOM COVERAGES

2. Has the **Applicant** incurred any crime or kidnap and ransom related losses or incidents during the past 3 years? Yes ☐ No ☐
   If Yes, please complete the table below:

Date of Loss/Incident	Amount of Loss	Description of Loss	Corrective Procedures Implemented	Current Status
	$			
	$			

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

IDENTITY FRAUD EXPENSE REIMBURSEMENT COVERAGE

3. Has the **Applicant** experienced, in the last 3 years, a data theft, data breach, or loss of employee, customer or member information? Yes ☐ No ☐
   If Yes please attach an explanation.

B. PRIVATE PARTNERSHIP LIABILITY COVERAGE SECTION

I. REQUIRED ATTACHMENTS – PRIVATE PARTNERSHIP LIABILITY

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 statements for all entities requesting coverage
- List of Board of Managers, Directors and Officers or functional equivalent for each LLC or incorporated entity requesting coverage
- Any Private Placement Memorandums issued within the previous 12 months or anticipated in the next 12 months
- Organization chart with ownership details for all entities requesting coverage

C. EMPLOYMENT PRACTICES LIABILITY COVERAGE SECTION

I. EMPLOYEE INFORMATION

1. Complete the following chart providing employee information for the ***5 states or foreign countries*** with the greatest number of **Applicant** employees *(attach a separate sheet if necessary)*:

State or Foreign Country	Number of Employees

2. Complete the following chart providing the *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):

Leased	Temporary	Seasonal	Union

3. Number of employees: a. Compensated **less than** $50,000 annually: _____
   b. Compensated **more than** $100,000 annually: _____
4. Within the past 24 months has the **Applicant** or outside employment counsel completed an audit regarding the payment of wages, including equal pay and overtime pay? Yes ☐ No ☐
5. What percentage of the **Applicant's** employee base is: Exempt: _____% Nonexempt: _____%
6. Within the past 24 months has the **Applicant** or outside employment counsel completed an audit regarding the classification of individuals as exempt v. non-exempt employees or as independent contractors? Yes ☐ No ☐
7. Complete the following chart providing employee turnover figures for each of the last 3 years:

Number of Terminations	Year - 20____	Year - 20____	Year - 20____
Voluntary			
Involuntary (excluding layoffs/downsizing)			
Layoffs/Downsizing			

8. Within the past 24 months how many officers have been involuntarily terminated or laid off? _____
9. Prior to employee terminations does the **Applicant** consult with:
   a. Human Resources personnel? Yes ☐ No ☐
   b. An attorney with experience in employment law? Yes ☐ No ☐
10. a. Does the **Applicant** provide severance packages to terminated or laid off employees? Yes ☐ No ☐
    b. If Yes, does the severance agreement include a waiver or release of an employee's rights to bring claim against the **Applicant**? Yes ☐ No ☐

II. HUMAN RESOURCES

1. a. Does the **Applicant** have a Human Resources department? Yes ☐ No ☐
   b. Number of Human Resources employees: _____
2. Are all prospective employees required to complete a uniform employment application prior to hire? Yes ☐ No ☐
3. Does the **Applicant** have an employee handbook that is distributed to all employees? Yes ☐ No ☐
4. Are employees required to acknowledge, by signature, receipt of such employee handbook? Yes ☐ No ☐
5. Does the employment application or employee handbook contain an "Employment at Will" statement? Yes ☐ No ☐

6. Complete the following chart for guidelines, policies and procedures related to the following:

Guidelines, Policies, Procedures	Formal Written Policy	Employees Sign and Acknowledge Receipt
Discrimination	Yes ☐ No ☐	Yes ☐ No ☐
Sexual and Other Workplace Harassment	Yes ☐ No ☐	Yes ☐ No ☐
Equal Employment Opportunity	Yes ☐ No ☐	Yes ☐ No ☐
FMLA	Yes ☐ No ☐	Yes ☐ No ☐
Disabled Employees and Accommodations	Yes ☐ No ☐	Yes ☐ No ☐
Retaliation	Yes ☐ No ☐	Yes ☐ No ☐
Reporting, Investigating and Resolving Employee Complaints	Yes ☐ No ☐	Yes ☐ No ☐
Written Performance Appraisals/Reviews	Yes ☐ No ☐	Yes ☐ No ☐
Hiring/Interviewing	Yes ☐ No ☐	
Discharge/Termination	Yes ☐ No ☐	

7. Are the **Applicant's** employment practices policies, procedures and employee handbook periodically reviewed by an attorney with experience in employment law? Yes ☐ No ☐

8. Does the **Applicant** have written policies or procedures outlining employee conduct when dealing with the general public, customers, clients, vendors, or other third parties? Yes ☐ No ☐

9. Does the **Applicant** have written policies or procedures for dealing with complaints from the general public, customers, clients, vendors, or other third parties for issues involving harassment or discrimination? Yes ☐ No ☐

10. Does the **Applicant** conduct human resources training on guidelines, policies and procedures for all individuals who handle human resources functions? Yes ☐ No ☐

11. Does the **Applicant** conduct training for employees on issues of discrimination and sexual and other workplace harassment? Yes ☐ No ☐

12. If the **Applicant** is a federal contractor subject to the OFCCP, has the **Applicant** been subject to a compliance evaluation or investigation in the last 3 years? N/A ☐ Yes ☐ No ☐
If Yes, please attach an explanation.

III. REQUIRED ATTACHMENTS – EMPLOYMENT PRACTICES LIABILITY

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 all entities requesting this coverage
- If **Applicant** has 500 or more employees, attach employee handbook
- If **Applicant** has 1,000 or more employees, most recent EEO-1 report and complete the Wage and Hour Supplemental Application
- If **Applicant** is a *contractor*, complete the Construction Supplemental Application
- If **Applicant** layoffs are either 10% of the workforce or more than 100 employees, complete the Downsizing Supplemental Application

D. FIDUCIARY LIABILITY COVERAGE SECTION

I. 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
		$	$		
		$	$		
		$	$		
* Defined Benefit (DB) Defined Contributions (DC) ESOP (E) Self-Funded Welfare Benefit Plan (W) Other (O) – Attach explanation					
** Active (A) Frozen (F) Sold (S) Terminated (T) – Include date of termination					

List any additional plans on a separate attachment.

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

CPA	Attorney	Actuary	Investment Advisor

III. REQUIRED ATTACHMENTS – FIDUCIARY LIABILITY

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
- Employer Securities Supplemental Application, if any plan is an ESOP or if any other defined contribution plan invests in employer securities
- Most recent 5500 of all plans

E. CRIME COVERAGE SECTION

I. PROPOSED ADDITIONAL INSUREDS (OTHER THAN APPLICANT)*

1. Complete the following table indicating all additional entities for which coverage is requested:

Name of Entity	Description of Operations and Relationship to Applicant

To enter more information, please attach a separate page or an organization chart.

***IMPORTANT NOTE:** **Receipt of this information does not constitute an agreement that coverage will be provided to the listed entities.**

II. EMPLOYEE/LOCATION/EXPOSURE INFORMATION

1. Number of locations outside the United States: _____
   Indicate domicile of each on a separate page.
2. Indicate the total amount of specified property *INSIDE* the premises for all locations combined:
   Cash $_____ Retail Checks** $_____ Credit Card Receipts $_____
3. Indicate the total amount of specified property being transported by a messenger *OUTSIDE* the premises for all locations combined:
   Cash $_____ Retail Checks** $_____ Credit Card Receipts $_____

** *Retail Checks are only those checks that are accepted as immediate payment for retail products or services.*

III. INTERNAL CONTROLS

1. Are bank account statements reconciled at least monthly? Yes ☐ No ☐
2. Does someone other than the person responsible for reconciling bank accounts:
   Make deposits? Yes ☐ No ☐ Make withdrawals? Yes ☐ No ☐ Sign checks? Yes ☐ No ☐
3. Is countersignature of checks required? Yes ☐ No ☐
   If Yes, what is the dual signing limit? $_____
4. Is segregation of duties practiced in the following areas:
   Inventory management? Yes ☐ No ☐ Cash receipts? Yes ☐ No ☐
   Vendor approval? Yes ☐ No ☐ Oversight of blank check stock? Yes ☐ No ☐
   Purchase order approval and payment? Yes ☐ No ☐ Retail checks and credit card receipts? Yes ☐ No ☐
5. Are all incoming checks stamped “for deposit only” immediately upon receipt? Yes ☐ No ☐
6. Are deposits of cash and checks made at least daily? Yes ☐ No ☐
7. Is a physical count of inventory conducted at least annually? Yes ☐ No ☐
8. Do you conduct periodic reviews of all unused or obsolete inventory (including raw materials and scrap metals)? N/A ☐ Yes ☐ No ☐

9. Are inventory records computerized? Yes ☐ No ☐

10. Are the duties of computer programmers and computer operators separated? Yes ☐ No ☐

11. Are the same internal controls listed above imposed on all locations and entities? Yes ☐ No ☐

IV. COMPUTER AND FUNDS TRANSFER CONTROLS

1. Is there a software security system in place to detect fraudulent computer usage by employees, agents and outsiders? Yes ☐ No ☐

2. Are passwords and access codes changed at regular intervals and when users are terminated? Yes ☐ No ☐

3. Are computer programmers permitted to use machines with programs they have written? Yes ☐ No ☐

4. Are computer check writing functions separate from check authorization? Yes ☐ No ☐

5. Are EDP systems, programs, and procedures, including changes thereto, authorized, documented and tested? Yes ☐ No ☐

6. Is there physical and functional segregation of personnel and periodic job shifts or job rotations? Yes ☐ No ☐

7. Is dual authorization required for all wire transfers? N/A ☐ Yes ☐ No ☐

8. What is the average daily dollar volume of electronic funds transfers? $ _____
Check if not applicable ☐.

9. Are transfer verifications sent to an employee or department other than the one that initiated the transfer? Yes ☐ No ☐

V. BUSINESS PRACTICES AND PHYSICAL CONTROLS

1. Indicate if you have or perform any of the following *(check all that apply)*:

Business Practices/Policies		Physical Controls		Hiring/Screening Practices	
Formal written business plan	☐	Guards/watchmen	☐	Prior employment verification	☐
Fraud policy	☐	Messengers	☐	Drug testing	☐
Confidential hotline or procedure for employees to report violations in your policies	☐	Premises alarm systems	☐	Education verification	☐
		Controlled premises access	☐	Credit history	☐
Code of ethics	☐	Other protection	☐	Criminal history	☐
Conflict of interest policy	☐				

VI. UNIQUE/SIGNIFICANT EXPOSURES

1. Indicate any of the following characteristics or exposures that apply to your business operations *(check all that apply)*:

Precious metals or gemstones	☐	Narcotics	☐
High unit, portable inventory	☐	Computer chips	☐
Managed assets of others	☐	Proprietary trading activity	☐
Warehousing operations	☐	Care, custody and control of clients' property	☐
Art collection or other valuable collectibles	☐	None applicable	☐

If you checked any of the characteristics or exposures above, please provide details that quantify the exposure and briefly describe the controls in place to protect you from loss in a separate attachment.

VII. REQUIRED ATTACHMENTS - CRIME

As part of this Application, please submit the following documents:

- Most recent annual financial statement, for limit requests of $5,000,000 or greater
- CPA Management Letter, if prepared, as well as management's response thereto, for limit requests of $5,000,000 or greater
- If coverage for Employee Theft of Client Property (Third Party Crime) is requested, submit separate Third Party Crime Application

F. KIDNAP AND RANSOM COVERAGE SECTION

I. ORGANIZATION INFORMATION

1. Are any operations to be insured involved in the production of foodstuffs, beverages or pharmaceuticals (including toothpaste, mouthwash, etc.)? Yes ☐ No ☐
   If Yes, please attach an explanation.
2. Does the **Applicant** own or operate, or know of any persons for whom it seeks coverage under this insurance that will work or travel on any ships, vessels, tugs, barges or rigs? Yes ☐ No ☐

II. FOREIGN EXPOSURE

Please complete the following questions regarding foreign locations and travel.

1. Do Directors, Officers or other employees of the **Applicant** take trips outside the United States and Canada? Yes ☐ No ☐
   If Yes, please provide travel information for the previous 12 months and estimates of the upcoming 12 months:

City and Country of Destination	# of Trips	# of Individuals	Average Length of Trips

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

2. Are there any permanent foreign locations of the **Applicant**? Yes ☐ No ☐
   If Yes, please provide both the existing and anticipated foreign locations:

City and Country	# of Locations	Type of Operation (i.e. Sales, Manufacturing)	# of Employees

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

3. Are steps taken to ensure an Insured Person's safety when traveling outside the United States? Yes ☐ No ☐
   If Yes, please attach an explanation.
4. Are steps taken to ensure the safety of Insured Persons and Premises permanently located outside of the United States? Yes ☐ No ☐
   If Yes, please attach an explanation.

G. IDENTITY FRAUD EXPENSE REIMBURSEMENT COVERAGE SECTION

I. ORGANIZATION INFORMATION

1. Does the **Applicant** maintain privacy policies pertaining to employee information? Yes ☐ No ☐
2. Does the **Applicant** have loss prevention or loss mitigation protocols for addressing a potential information breach? Yes ☐ No ☐

II. CONTACT INFORMATION

Contact Name: _____

Email: _____ Phone: _____

H. 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.

I. 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.

J. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PRESIDENT, CEO, 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 (President or CEO)

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 ☐

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

Producer Signature

Producer Name (Printed)

Agency Name

Agency Code

License Number