TRAVELERS

**Travelers Casualty and Surety Company of America** **Fiduciary Liability Renewal Coverage 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 limits of liability will be reduced, and may be completely exhausted, by amounts paid as defense expenses. The Insurer will not be liable for the amount of any judgment, settlement, or defense expenses incurred after exhaustion of the limit of liability. (For policies issued in New York, the limit of liability may be reduced up to 50% for amounts paid as defense expenses).

## *IMPORTANT INSTRUCTIONS*

This Application will not be accepted for plans sponsored by a union or a governmental entity, a pooled plan provider, a plan open to multiple employers, or a direct filing entity (DFE).

Under the Fiduciary Liability policy, plans open to entities, other than Subsidiaries as defined in the policy, are not covered unless the Company has agreed to specifically schedule such plans by endorsement.

Some of the information in this Application may be prefilled based on previously provided information. Make appropriate changes if necessary.

## *GENERAL INFORMATION*

| | | | |
|---|---|---|---|
| Name of Applicant: | | | |
| Street Address: | | | |
| City: | | State: | Zip: |
| Primary Contact Name and Title: | | Telephone Number: | |
| Email Address: | | Applicant Website: | |
| Expiring Policy Number: | NAICS Code: | Applicant's Federal Employer ID Number (EIN)/Taxpayer Identification Number (TIN): - | |
| Sponsor Type (select primary type): ☐ Private | ☐ Publicly Traded | ☐ Non-Profit | |
| ☐ Private Financial Institution | ☐ Publicly Traded Financial Institution | ☐ Non-Profit Financial Institution | |
| Total full-time employees: | Total part-time employees: | Highest number of participants in any one plan: | Total natural person independent contractors: |

## *PLAN INFORMATION*

1. Is the policy premium paid by the trust or plan? ☐ Yes ☐ No

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

| Plan Name | Plan Year | Plan Type* | Total Assets | % Total Assets in Employer Securities | % Total Assets in Proprietary Funds (Financial Institutions Only) | Funded % (DB or W Plans Only) |
|---|---|---|---|---|---|---|
| | | | $ | % | % | % |
| | | | $ | % | % | % |
| | | | $ | % | % | % |

*Plan Type: DB = Defined Benefit; DC = Defined Contribution; DE = Employee Stock Ownership Plan; S = Simple IRA Plan; W = Self-Funded or Self-Insured Welfare Benefit Plan; O = Other—Attach explanation

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


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## *PLAN INFORMATION (CONTINUED)*

3. Does the Applicant participate in any multiple employer plan or pooled employer plan that they do not sponsor? ☐ Yes ☐ No

4. Are any plan investment decisions made in-house? ☐ Yes ☐ No

5. 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

6. In the past 3 years, were there any non-exempt transactions with any party-in-interest to any plan? ☐ Yes ☐ No

7. Has the Applicant or any plan entered any voluntary compliance resolution program or similar voluntary settlement program administered by the Internal Revenue Service (IRS), Department of Labor (DOL), or Pension Benefit Guaranty Corporation (PBGC)? ☐ Yes ☐ No

8. If the Applicant has a defined benefit plan or a self-funded welfare plan, answer the following:
   a. In the past 3 years, has any plan amendment resulted in a reduction of benefits? ☐ Yes ☐ No ☐ N/A
   b. In the past 3 years, has any plan been converted to a cash balance plan, merged with another plan, terminated, frozen, or sold? ☐ Yes ☐ No ☐ N/A

*If Yes to any of the above, provide details in a separate attachment to the Application.*

## *REQUESTED INSURANCE TERMS*

9. Requested Terms:
   Limit Requested: $ _____
   Retention Requested: $ _____

10. If the Applicant is requesting a limit that is greater than its expiring limit, is any Applicant, any benefit plan, or any person proposed for this insurance, aware of any circumstance that could reasonably give rise to a claim against them under this Fiduciary Liability coverage? ☐ Yes ☐ No ☐ N/A

    *If Yes, provide details in a separate attachment to the Application.*

## *REQUIRED ATTACHMENTS*

As part of this Application, provide copies of the documents listed below. Such documents are made a part of this Application, and the Company may elect to obtain requested information from public sources, including the internet.

- For private and non-profit Applicants with any defined benefit plan, self-funded welfare plan, or Employee Stock Ownership Plan (ESOP), provide the Applicant's most recent audited financial statement and the latest interim financial statement.
- Applicant's most recent audited financial statement and plan financial statements for each defined contribution plan, if limit requested is greater than $5,000,000.
- Plan financial statements for all defined benefit plans and self-insured welfare plans, if limit requested is greater than $1,000,000.
- Employer Securities Supplemental Application, if any plan is an Employee Stock Ownership Plan (ESOP) or if any other defined contribution plan invests in Applicant securities.

## *ORGANIZATIONS NOT ELIGIBLE FOR COVERAGE*

Coverage will not be considered for companies involved in whole or in part in 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.

**CALIFORNIA:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.


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**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 their knowledge and belief, and after reasonable inquiry, the statements provided in response to this Application are true and complete, and, except in North Carolina, 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. Except in North Carolina and Utah, this Application, including any requested or submitted information, will be deemed attached to and form a part of any policy issued.

☐ 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 (Partner, Principal, Trustee, Officer, or Risk Manager):<br>**X** | Authorized Representative Name and Title: | Date *(month/dd/yyyy)*: |
| Producer Name (required in FL & IA):<br>**X** | State Producer License No (required in FL): | Date *(month/dd/yyyy)*: |
| Agency: | | Agency Phone Number: |


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