

CORPORATE FIDUCIARY LIABILITY INSURANCE APPLICATION



Notice: The policy for which application is made applies, subject to its terms, only to any claim first made or deemed made against the *Insured* during the *Policy Period* or any applicable *Extended Reporting Period*. This policy provides that the limit of liability available to pay judgments or settlements may be reduced by *Claim Expenses*, and that *Claim Expenses* may be applied against any applicable deductible.

Agent/Broker	Code:	Name:	License Number:
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Insurer:	Policy Number:
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GENERAL INFORMATION

1. Name & Address of Insured (Sponsor Organization): _____ _____ _____	3. Total Number of Employees: 4. Maximum number of individuals in your workforce in the following capacities over the past 12 months: Temporary: _____ Leased: _____ Independent Contractors: _____ 5. Annual Sales or Revenues: _____ \$ _____ 6. Is this a Publicly Traded Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Description of Named Insured's Business: _____ EIN #: _____ SIC Code: _____	7. Years in Business: _____

INSURANCE INFORMATION

1. Expiring Fiduciary Liability Coverage: Limit: _____ Deductible: _____ Effective Date: _____ Expiration Date: _____ Premium: _____ Insurer: _____	4. Premium Payable: <input type="checkbox"/> Annually <input type="checkbox"/> Three Years Installment <input type="checkbox"/> Three Years prepaid Premiums to be Paid By: <input type="checkbox"/> Employer <input type="checkbox"/> Trust or Plan
2. Coverage Requested: Limit: _____ Deductible: _____ Effective/Expiration Date: _____	3. Insurance Representative (The individual acting as the exclusive agent to act on behalf of the Insureds in matters of this insurance): _____

(Endorsement will be issued to eliminate recourse on insureds who are fiduciaries if the premium is paid by the Employee Benefit Plan. Premium for this endorsement must be paid from funds other than the assets of the Employee Plan.)

LOSS INFORMATION

1.	Has any plan, entity or person proposed for this insurance been: a. Accused or found guilty or held liable for a breach of fiduciary duty, or a violation of ERISA, or any similar state, local or foreign law?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	b. Accused or found guilty or any criminal act?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2.	Has any fiduciary liability or fidelity coverage for any plan, entity or person proposed for this insurance ever been refused, canceled or non-renewed? (This question is not applicable to Missouri applicants)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

PRIOR COVERAGE (select one)						
1.	<input type="checkbox"/>	New policy with no prior similar coverage: Are there any facts or circumstances which may result in a claim under the proposed policy?	<input type="checkbox"/>	Yes*	<input type="checkbox"/>	No
2.	<input type="checkbox"/>	New policy with prior similar coverage with another insurer (Attach copy of the prior application for request for continuity of coverage):				
		a. Prior similar coverage has been continually in effect since mm/dd/yyyy. At the time of original application to the insurer who wrote such coverage, were there any facts or circumstances which might have resulted in a claim being made against any insured?	<input type="checkbox"/>	Yes*	<input type="checkbox"/>	No
		b. Are there any pending claims?	<input type="checkbox"/>	Yes*	<input type="checkbox"/>	No
		c. During the past five years, have any claims been brought against any plan, entity or person proposed for this insurance?	<input type="checkbox"/>	Yes*	<input type="checkbox"/>	No
3.	<input type="checkbox"/>	Renewal policy of the Company: a. Prior similar coverage has been continually in effect with The Hartford or any current or former affiliates since mm/dd/yyyy. b. Prior to obtaining coverage with The Hartford or any current or former affiliates, similar coverage has been continually in effect with another insurer since mm/dd/yyyy.				

* If Yes to any question above, attach details including type and amount of claim and whether any insurance responded.

PLAN DATA							
Complete the chart below for all plans for which coverage is requested. For <u>each</u> plan listed, indicate in the corresponding column the applicable letter(s) and number.							
Plan Type (Column 2)		Fund Status (Column 4)			Plan Status (Column 8)		
(DB) - Defined Benefit (DC) - Defined Contributions (W) - Welfare Benefit Plan (O) - Other - Attach explanation		1 - Trust 2 - Trust and Insurance 3 - Insurance 4 - Funded exclusively from general assets of the Sponsor (unfounded) 5 - Funded partially from insurance and partially from assets of the Sponsor			A - Active F - Frozen M - Merged T - Terminated S - Sold (Spun-off) If any plan has been merged, terminated or sold, indicate date of transaction.		
1. Full Plan Name*	2. Plan Type	3. Report Year	4. Fund Status	5. Asset Value (000)	6. Annual Contributions	7. No. of Participants	8. Plan Status
				\$	\$		
				\$	\$		
				\$	\$		

* List any additional plans on a separate sheet of paper.

Total assets of all plans to be covered under this policy:	\$
Total number of plan trustees and other employees who act in a fiduciary capacity:	

PLAN UNDERWRITING QUESTIONS					
1.	Has the IRS withdrawn or threatened to withdraw the tax-exempt status of any plan? If Yes, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2.	Has any plan experienced an event reportable to the PBGC within the past three years? If Yes, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3.	Has any plan been the subject of an investigation by the DOL, IRS or similar foreign regulatory agency in the last three years? If Yes, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4.	Does the plan(s) conform to the standards of eligibility, participation, vesting and other provisions of ERISA or similar foreign law? If No, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5.	Has any plan filed for exemption from a prohibited transaction? If Yes, attach copy of filing and DOL response.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6.	Has any actuary certified that the plans are adequately funded in accordance with ERISA's minimum funding standard? If No, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
7.	Is each plan reviewed periodically to assure there are no violations of prohibited transactions or party-in-interest rules of ERISA? If No, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
8.	Has any plan received an adverse opinion as to its financial condition by an independent public accountant? If Yes, attach copy of plan audit.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9.	Does any plan hold employer securities or employer real property in violation of ERISA or in excess of ERISA limits? If Yes, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

10.	Is any plan loan, lease or debt obligation in default or classified as uncollectible? If Yes, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
11.	Are there any outstanding delinquent plan contributions? If Yes, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
12.	Does any plan invest in or provide an option to invest in employer securities. If Yes, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
13.	In the past two years have there been any plan amendments or do you anticipate any plan amendments that will result in a reduction in benefits? If Yes, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
14.	Has any plan been merged with another plan, terminated or sold within the past two years or are any anticipated to be merged, terminated or sold in the next 12 months. If Yes, explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
15.	If any plan has been terminated, were benefits secured with the purchase of annuities? If Yes, please provide the name of the insurance carrier(s).	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
16.	Does the employer, committee of employer representatives, or union board of trustees have final say over the determination of whether benefits will be paid under any health and welfare plan sponsored by this Insured?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

INVESTMENT ADVISORS

Please list all outside professional investment advisor(s) utilized by the plan(s) listed on page 2.

If any plan does not utilize outside professional investment advisor(s), please attach a schedule of each plan's investments.

CURRENT INSURANCE COVERAGES

Policy	Limit	Deductible	Insurance Co.	Effective Date	Premium
Directors & Officers	\$	\$			\$
Errors & Omissions	\$	\$			\$
Employment Practices	\$	\$			\$
Fidelity/Crime	\$	\$			\$
Workers Comp.	\$	\$			\$
Commercial GL	\$	\$			\$

REQUIRED ATTACHMENTS

For Single Employer Plans or Controlled Groups of Corporations:

☞ Coverage limit requests of \$1,000,000 or greater attach:

- Sponsor financial statements,
- Form 5500's for each pension plan with attached schedules A, B, C, E (ESOP) and G, as applicable, and
- Plan financial statements for each pension plan.

Information requests may vary from the above based on specific account or industry characteristics.

IMPORTANT STATE INFORMATION

FRAUD WARNINGS

(Applicable in all jurisdictions, except for separate jurisdiction statements below)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

Attention: Insureds in New York

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

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 Tennessee and Virginia

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 Louisiana and New Mexico

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.

Attention: Insureds in Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

The undersigned declares that the statements set herein are true to the best of his or her knowledge and belief. The undersigned agrees that this application and attachments form the basis of the contract should a policy be issued and shall be deemed attached to and form part of a policy. The Company is hereby authorized to make any investigation and inquiry in connection with this application.

Signed by Trustee/Fiduciary: _____

Dated: _____

Print Name: _____

Title: _____