



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. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS MAY BE REDUCED BY THE AMOUNTS INCURRED AS "DEFENSE EXPENSES", AND "DEFENSE EXPENSES" MAY BE APPLIED AGAINST THE DEDUCTIBLE AMOUNT.

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

1. Name & Address of Insured (Sponsor Organization): _____ _____		5. Annual Sales or Revenues: \$ _____
		6. Is this a Publicly Traded Entity?: <input type="checkbox"/> Yes <input type="checkbox"/> No
		7. Years in Business: _____
2. Description of Named Insured's Business: _____		8. Sponsorship:
EIN#: _____	SIC Code: _____	<input type="checkbox"/> Single Employer or Controlled Group of Corporations
3. Total Number of Employees or Members*: _____		<input type="checkbox"/> Multi-Employer (Collectively-bargained)
		<input type="checkbox"/> Multi-employer
		<input type="checkbox"/> Multiple Employer <input type="checkbox"/> Church
		<input type="checkbox"/> Governmental <input type="checkbox"/> Other (Explain)
4. Maximum number of individuals in your workforce in the following capacities over the past 12 months:		
Temporary: _____	Leased: _____	Independent Contractors: _____

* For Single Employer/Controlled Group of Corporations or Governmental Sponsors indicate employees. For all other sponsors use total members.

INSURANCE INFORMATION

1. Expiring Fiduciary Liability Coverage: Limit _____ Deductible _____ Eff/Exp Date _____ Premium _____ Insurer _____	4. Premium Payable: <input type="checkbox"/> Annually <input type="checkbox"/> Three Years Installment <input type="checkbox"/> Three Years Prepaid
2. Coverage Requested: Deductible _____ Limit _____ Eff/Exp Date _____	Premium to be Paid By: <input type="checkbox"/> Employer or Union <input type="checkbox"/> Trust or Plan
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:	<u>Yes</u>	<u>No</u>
(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"/>	<input type="checkbox"/>
(b) Accused or found guilty of any criminal act?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR COVERAGE (select one)

I. <input type="checkbox"/> New Policy with no prior similar coverage:	<u>Yes</u>	<u>No</u>
(a) Are there any facts or circumstances which may result in a claim under the proposed policy?	<input type="checkbox"/>	<input type="checkbox"/>
II. <input type="checkbox"/> New Policy with prior similar coverage with another insurer (Attach a copy of the prior application for request for continuity of coverage):		
(a) Prior similar coverage has been continually in effect since ____/____/____. 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"/>	<input type="checkbox"/>
(b) Are there any pending claims?	<input type="checkbox"/>	<input type="checkbox"/>
(c) During the past five years, have any claims been brought against any plan, entity or person proposed for this insurance?	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR COVERAGE (continued)

- III. Renewal Policy of the Company:
- (a) Prior similar coverage has been continually in effect with Travelers Property Casualty or any current or former affiliates since ____/____/____.
 - (b) Prior to obtaining coverage with Travelers Property Casualty or any current or former affiliates, similar coverage has been continually in effect with another insurer since ____/____/____.

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

PLAN DATA

Complete Chart for all plans for which coverage is requested. For each 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)
Defined Benefit (DB) Defined Contribution (DC) Welfare Benefit Plan (W) Other (O) - Attach Explanation	1. Trust 2. Trust and Insurance 3. Insurance 4. Funded exclusively from general assets of the Sponsor (unfunded) 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 attachment

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

	<u>Yes</u>	<u>No</u>
1. Has the IRS withdrawn or threatened to withdraw the tax exempt status of any plan? If Yes, explain.	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any plan experienced an event reportable to the PBGC within the past three years? If Yes, explain.	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
5. Has any plan filed for exemption from a prohibited transaction? If Yes, attach copy of filing and DOL response.	<input type="checkbox"/>	<input type="checkbox"/>
6. Has an actuary certified that the plans are adequately funded in accordance with ERISA's minimum funding standard? If No, explain.	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
10. Is any plan loan, lease or debt obligation in default or classified as uncollectible? If Yes, explain.	<input type="checkbox"/>	<input type="checkbox"/>
11. Are there any outstanding delinquent plan contributions? If Yes, explain.	<input type="checkbox"/>	<input type="checkbox"/>
12. Does any plan invest in or provide an option to invest in employer securities? If Yes, explain.	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>

INVESTMENT ADVISORS

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

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

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

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.

Attention: Insureds in KY

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.

Signed by Trustee/Fiduciary: _____ Dated: _____

Print Name: _____

Title: _____