TRAVELERS

St. Paul Fire and Marine Insurance Company

Fiduciary Dishonesty Bond For Employee Benefit Plans Renewal Application

GENERAL INFORMATION

Fiduciary Name:

Fiduciary Address:

City:	State:	Zip:

Fiduciary Website:

Year Fiduciary Established:	Total No. of Employees:	No. of U.S. Locations:	No. of Foreign Locations:

EXPOSURE INFORMATION

1. Please complete the following information:

   Current number of ERISA client plans under management: _____

   Current dollar value of ERISA client plans under management: $ _____

2. Aggregate Limit of Liability required for all ERISA client plans under management: $ _____

   The Aggregate Limit equals the sum of the required Bond amounts for all ERISA Plans. The required Bond amount for each Plan equals the lesser of 10% of assets handled or $500,000 (or $1,000,000 if the Insured Plan holds employer securities or if the Insured Plan is a pooled employer plan), subject to a minimum of $1,000 per Section 412 of ERISA.

3. Do you want coverage for Non-ERISA client plans under management? ☐ Yes ☐ No

   If Yes, number of Non-ERISA client plans to be covered: _____

   Aggregate Limit of Liability required for covered Non-ERISA client plans under management: _____

   Calculate the same as Question 2.

4. Have you had any losses of the type to be covered by this Bond within the last six years? ☐ Yes ☐ No

   If Yes, please attach a list of such losses, including the date, circumstances, and amount of the loss for each.

5. Do you carry Fidelity Bond coverage on your own firm? ☐ Yes ☐ No

   If Yes, who provides the coverage and what is the limit of coverage? _____

6. Are you registered as a Pooled Plan Provider? ☐ Yes ☐ No

7. Have there been any material changes to the answers you furnished in your most recent application for this coverage? ☐ Yes ☐ No

   If Yes, please explain: _____

As part of this Application, please provide copies of the documents listed below. Such documents are made a part of this Application; the Insurer may elect to obtain requested information from public sources, including the Internet.

- A copy of your most recent, filed Form ADV, provide details for any "yes" answers to Item 11 of Part 1A.
- Your most recent fiscal year end audited financial statements, CPA management letter (if available), and your responses to management letter recommendations.
- Any applicable explanatory comments.

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.

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 his or her 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: **X**	Authorized Representative Name and Title:	Date *(month/dd/yyyy)*:
Producer Name (required in FL & IA): **X**	State Producer License No (required in FL):	Date *(month/dd/yyyy)*:
Agency:		Agency Phone Number: