TRAVELERS

**Executive Choice+®**
***Fiduciary Liability***
***Renewal Coverage Application***

**Travelers Casualty and Surety Company of America**

**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.**

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

## I. GENERAL INFORMATION

1. **Applicant** Information:

   Name of **Applicant**: _____

   Street Address: _____

   City, State, ZIP Code: _____

   Expiring Policy Number: _____

## II. ORGANIZATION INFORMATION

1. In the next 12 months (or during the past 12 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 branch, location, facility, office, or subsidiary closings, consolidations or layoffs? Yes ☐ No ☐

   *If either of the questions above were answered Yes, please attach an explanation, including the timing, the essential terms of the event, arrangement, and the surrounding circumstances.*

## III. EMPLOYEE INFORMATION

1. 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):

| Total Employees (Including leased, union, independent contractors and temporary employees) | Leased | Labor Unions | Independent Contractors | Temporary |
|---|---|---|---|---|
| | | | | |

## IV. 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 |
|---|---|---|---|---|---|
| | | $ | $ | | |
| | | $ | $ | | |
| | | $ | $ | | |
| | | $ | $ | | |
| | | $ | $ | | |

***Plan Types:** **Defined Benefit (DB) - Defined Contributions (DC) - ESOP (E) - Self-Funded Welfare Benefit Plan (W) - Other (O) – Attach Explanation**

****Plan Status:** **Active (A) - Frozen (F) - Sold (S) - Terminated (T) (If any plan has been terminated, indicate date of transaction)**

List any additional plans on a separate attachment.

## V. PLAN UNDERWRITING QUESTIONS

1. 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.*

2. 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.*

3. 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.*

4. 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.*

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 ☐
   *If Yes, please attach an explanation.*

6. Does any plan invest in a mutual fund, collective trust or similar investment pool that receives investment management services from the **Applicant** for a fee? Yes ☐ No ☐
   *If Yes, please attach an explanation.*

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

| CPA | Attorney | Actuary | Investment Advisor |
|---|---|---|---|
| | | | |

## VI. EMPLOYER SECURITIES

*Please complete this section only if the **Applicant** sponsors an ESOP or a defined contribution plan that invests in employer securities.*

1. Name of plan(s) holding employer securities:

   _____

   _____

2. As a matter of plan design, is company stock required to be offered as an investment alternative? Yes ☐ No ☐

3. If the plan is an ESOP, is it leveraged? N/A ☐ Yes ☐ No ☐
   *If Yes, provide the date, terms and reasons for loan as well as the names of any parties selling shares to the ESOP and list any guarantors of the loan:*

   _____

   _____

4. Does an independent trustee or other fiduciary not otherwise affiliated with the **Applicant** monitor the plan's stock holdings? Yes ☐ No ☐
   *If Yes, provide the name of all independent trustees or other fiduciaries.*

5. Does the plan allow immediate diversification of contributions made in company stock? Yes ☐ No ☐
   *If No, please describe if and when diversification is allowed.*

6. Does the plan include a provision for pass-through voting and tendering of allocated employer securities held by the plan and "mirrored" voting and tendering of unallocated employer securities held by the plan? Yes ☐ No ☐
   *If No, please provide an explanation.*

7. Does the plan have percentage caps on the amount of an employee's plan account that can be invested in company stock? Yes ☐ No ☐
   *If Yes, please provide the percentage amount:* _____ %

## VII. REQUESTED INSURANCE TERMS

1. Does the **Applicant** desire any changes to the expiring policy limit or retention? Yes ☐ No ☐
   *If Yes, please indicate the desired changes in the table below:*

| Expiring Limit (A) | Requested Limit (B) | Expiring Retention (C) | Requested Retention (D) |
|---|---|---|---|
| $ | $ | $ | $ |

*Do not answer the next question unless the Requested Limit in Column (B) exceeds the Expiring Limit in Column (A).*

2. Solely with respect to the higher limits requested or that may ultimately be issued for the proposed renewal, 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? Yes ☐ No ☐
   *If Yes, please attach an explanation.*

   *Solely with respect to any portion of the Limit for this Liability Coverage in the proposed policy that exceeds the amount of the Expiring Limit for this Liability Coverage in the expiring policy, 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.*

## VIII. REQUIRED ATTACHMENTS

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 and/or the plan invests in employer securities
- Most recent 5500 of all plans

## IX. 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.

## X. 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.

## XI. SIGNATURE SECTION

**THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PARTNER, PRINCIPAL, TRUSTEE 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 (Partner, Principal, Trustee or Officer)

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** ☐

## XII. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE):

Producer Signature

Producer Name (Printed)

Agency Name

Agency Code

License Number