TRAVELERS

Identity Fraud Expense Reimbursement Master Policy Application

Travelers Casualty and Surety Company of America

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, whose employees are to be covered under this insurance.

I. GENERAL INFORMATION

1. **Applicant** Information:

   Name of **Applicant**: _____

   Street Address: _____

   City, State, ZIP Code: _____

   Website Address: _____

   Expiring Policy Number: _____

   Year **Applicant's** business was established: _____

   Description of **Applicant's** operations: _____

2. **Applicant's** Standard Industrial Classification (SIC) code, if known (4-digit number): _____

II. ORGANIZATION INFORMATION

1. Total number of proposed insureds as of the policy effective date: _____
   (total number should not include spouses or family members)

2. Please describe how the proposed insured are categorized or grouped and their relationship to the applicant:

   Group One: _____

   Group Two: _____

3. Does the **Applicant** maintain privacy policies pertaining to customer information? Yes ☐ No ☐

4. Does the **Applicant** have loss prevention or loss mitigation protocols for addressing a potential information breach? Yes ☐ No ☐

III. REQUESTED INSURANCE TERMS

1. Please complete the table below:

Effective Date	Requested Limit				Requested Retention			
Group One	$ 1,000 ☐	$10,000 ☐			$ 0 ☐	$250 ☐		
	$ 5,000 ☐	$25,000 ☐			$100 ☐			
Group Two (if applicable)	$ 1,000 ☐	$10,000 ☐			$ 0 ☐	$250 ☐		
	$ 5,000 ☐	$25,000 ☐			$100 ☐			
Optional Coverages Requested	Spouse/Domestic Partner Coverage ☐							
	Family Coverage (includes Spouse/Domestic Partner) ☐							
	Identity Fraud Resolution Services ☐							

IV. LOSS INFORMATION

1. Has the **Applicant** experienced, in the last 3 years, a data theft, data breach, or loss of employee, customer or member information? Yes ☐ No ☐
   If Yes, please attach an explanation.

2. Is the **Applicant** currently aware of any situation that may cause a loss under this policy? Yes ☐ No ☐
   If Yes, please attach an explanation.

V. CONTACT INFORMATION

Contact Name: _____

Email: _____ Phone: _____

VI. 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.

VII. 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.

VIII. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE 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	Name (Printed)
Title	Date

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

Producer Signature	Producer Name (Printed)	
Agency Name	Agency Code	License Number