



**APPLICATION FOR NOT-FOR-PROFIT ORGANIZATION  
DIRECTORS, OFFICERS AND TRUSTEES LIABILITY INSURANCE INCLUDING  
EMPLOYMENT PRACTICES LIABILITY COVERAGE**

**NOTICE: THE INSURANCE FOR WHICH APPLICATION IS MADE UNDER SECTION I BELOW APPLIES, SUBJECT TO ITS TERMS, ONLY TO ANY "CLAIM" FIRST MADE AGAINST THE "INSUREDS" DURING THE POLICY PERIOD. (NOT APPLICABLE TO CRIME INSURANCE.)**

**SECTION I**

1. a) Name of **Applicant**: \_\_\_\_\_  
(Wherever used, **Applicant** means the above entity and its subsidiaries.)  
b) Principal Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
c) Date of Incorporation: \_\_\_\_\_
2. Name and title of the officer who will be the Insurance Representative designated as the authorized agent to act on behalf of the **Applicant**, individually or collectively, in all matters relating to this insurance: \_\_\_\_\_
3. a) Please provide a brief description of the **Applicant's** operations: \_\_\_\_\_  
\_\_\_\_\_  
b) Does the **Applicant** have any subsidiaries or control any other entity or organization?  Yes  No  
If "Yes," please attach a description of the organizational structure, the operations, the ownership, and the tax status of each such entity.  
c) Does the **Applicant** or any entity described in 3.b) above render any professional services, including but not limited to acting as agent or broker of insurance or providing any standard setting, accrediting, credentialing or licensing activities?  Yes  No  
If "Yes," please explain: \_\_\_\_\_  
\_\_\_\_\_  
d) Total number of compensated employees: \_\_\_\_\_ Total number of volunteers: \_\_\_\_\_  
e) Does the **Applicant** sponsor any pension or health and welfare benefit plan?  Yes  No
4. a) Does another entity own or control the **Applicant**?  Yes  No  
b) Has the **Applicant** or any subsidiary during the last five (5) years been the subject of any antitrust investigation or the subject of any claim or allegation of violation of any laws relating to antitrust, restraint of trade or unfair competition?  Yes  No  
If "Yes" to either 4.a) or 4.b), please explain: \_\_\_\_\_  
\_\_\_\_\_
5. a) Does the **Applicant** now have tax-exempt status under the U.S. Internal Revenue Code?  Yes  No  
b) If the answer to 5.a) is "Yes," has there been, or is there, any pending dispute as to the **Applicant's** tax-exempt status?  Yes  No

- c) If the answer to 5.a) is "No," has the **Applicant**:  not yet applied, or  
 applied and not yet been approved, or  
 applied and been denied?

6. a) Please provide financial information for the **Applicant's** current fiscal year by attaching the **Applicant's** current financial statements. (If Revenue amount or Total Assets exceed \$5,000,000, please attach current CPA-audited financial statements.)
- b) Prior to binding coverage, the Underwriter, in its sole discretion, may request any or all of the following:
- i) Complete copies of the **Applicant's** last CPA-audited financial statements with notes. If these are not consolidated, the Underwriter may request financial statements on each unconsolidated entity.
  - ii) The names and occupations of the **Applicant's** board of directors and trustees.
  - iii) Copies of the **Applicant's** charter and bylaws.
  - iv) Copies of brochures and publications produced by the **Applicant**.

7. a) Please provide information on other insurance currently in effect as indicated below:

Coverage Type	Yes √	No √	Insurer	Limits	Deductible	Premium	Expiration Date
D&O Liability							
CGL							
Commercial Crime							

- b) **MISSOURI APPLICANTS/AGENTS - DO NOT ANSWER THIS QUESTION.**

Have any of the above carriers indicated an intent not to offer renewal terms?  Yes  No  
 If "Yes," please attach an explanation.

8. Does the **Applicant's** organization have a plan to ensure that the **Applicant** and the **Applicant's** vendors and suppliers have information processing (hardware and software) systems which effectively eliminate the so-called "millennium bug" or "year 2000" issues?  Yes  No  
 If "Yes," please attach the plan.  
 If "No," please describe the steps which are being taken to address these issues: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (Please attach additional sheets, if necessary.)

9. Please complete the following. Does the **Applicant**:
- have a full-time human resources coordinator?  Yes  No
  - have a written policy with respect to sexual harassment?  Yes  No
  - have written annual evaluations for employees?  Yes  No
  - have a written policy with respect to progressive discipline for employees?  Yes  No
  - have a written policy for Family Medical Leave?  Yes  No
  - have a written human resources manual or equivalent written guidelines?  Yes  No
  - use outside counsel for employment advice?  Yes  No
  - have any collective bargaining agreements?  Yes  No

If "Yes," please describe and provide the total number of employees subject to such agreements.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. Past activities:

- a) No claim that would fall within the scope of the proposed insurance has been made against any person or entity proposed for this insurance (including without limitation any claim against any such person or entity for any employment practice, as described in the proposed insurance, or any complaint against any such person or entity before the Equal Employment Opportunity Commission or any similar state or local authority), except as follows (include loss payment and defense costs):

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(If none, check here:  "NONE.")

- b) No person or entity proposed for this insurance is cognizant of any fact, circumstance, or situation (including without limitation any suspected or threatened claim against any such person or entity for any employment practice, as described in the proposed insurance, or any suspected or threatened complaint against any such person or entity before the Equal Employment Opportunity Commission or any similar state or local authority) which might afford grounds for any claim that would fall within the scope of the proposed insurance, except as follows:

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(If none, check here:  "NONE.")

**Without prejudice to any other rights and remedies of the Underwriter, any claim arising from any claims, facts, circumstances or situations required to be disclosed in response to questions 10a) and 10b) is excluded from the proposed insurance.**

**COMMERCIAL CRIME INSURANCE APPLICATION  
FOR NOT-FOR-PROFIT ORGANIZATIONS**

<b>OPTIONAL SECTION COMPLETE SECTION II FOR CRIME INSURANCE</b>
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**SECTION II**

1.	COVERAGE REQUESTED	LIMIT OF INSURANCE	DEDUCTIBLE
	Coverage: - Employee Theft	\$ _____	\$ _____
	- Third Party Liability	\$ _____	\$ _____
	- Premises Coverage	\$ _____	\$ _____
	- Transit Coverage	\$ _____	\$ _____
	- Forgery, Alteration and Counterfeit Money	\$ _____	\$ _____
	- Computer Theft and Funds Transfer Fraud	\$ _____	\$ _____
	- Claims Expense	\$ _____	\$ _____
	- Extortion	\$ _____	\$ _____
	Other: _____	\$ _____	\$ _____

2. Does the **Applicant** want Employee Theft coverage to be extended to cover employee benefit plans sponsored by the **Applicant's** organization?  N/A  Yes  No  
If "Yes," please attach a list of all plan names and the corresponding assets/contributions.

3. **MISSOURI APPLICANTS/AGENTS - DO NOT ANSWER THIS QUESTION.**  
Has any commercial crime insurance been declined or canceled during the past three (3) years?  Yes  No  
If "Yes," please attach explanation.

4. Total number of employees: \_\_\_\_\_

5. Total number of locations: \_\_\_\_\_

6. Inside Premises: Indicate maximum exposure at any single location.

CASH	SECURITIES & CHECKS	NON-RETAIL CHECKS	PAYROLL CHECKS

7. Loss Experience: (During the last three (3) years, whether reimbursed or not)  Check if None

DATE	AMOUNT (\$)	DESCRIPTION OF LOSS	CORRECTIVE MEASURES

(Please attach a supplemental page if more space is needed.)

8. Control Procedures:
- a. If a CPA audit is performed, are all locations audited?  N/A  Yes  No
  - b. Does the **Applicant** have an internal audit department?  Yes  No
  - c. Are at least two signatures required on checks?  Yes  No
  - d. Do employees who reconcile monthly bank statements also sign checks, handle bank deposits or have access to check signing machines or signature plates?  Yes  No
  - e. Are checks stamped "For Deposit Only" as they are received?  Yes  No
  - f. Are the invoices stamped "PAID" at the time checks are issued?  Yes  No
9. Computer Controls:
- a. Is there a mechanism to prevent repeated attempts of unauthorized access to a computer program?  N/A  Yes  No
  - b. Are individuals responsible for authorizing checks also able to produce computerized checks?  N/A  Yes  No
  - c. Does the **Applicant** have an employee data security standards manual?  N/A  Yes  No

### SECTION III-ALL COVERAGES

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE UNDERWRITER TO COMPLETE THE INSURANCE.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE UNDERWRITER AND ALONG WITH THE APPLICATION IS CONSIDERED PHYSICALLY ATTACHED TO THE POLICY AND WILL BECOME PART OF IT. THE UNDERWRITER HAS RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING THIS POLICY. THIS APPLICATION WILL BECOME PART OF SUCH POLICY IF ISSUED.

IF THE INFORMATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL NOTIFY THE UNDERWRITER, WHO MAY MODIFY OR WITHDRAW THE QUOTATION.

THE UNDERSIGNED DECLARES THAT THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE UNDERSTAND THAT THE INSURANCE FOR WHICH APPLICATION IS MADE UNDER SECTION I ABOVE APPLIES ONLY TO "CLAIMS" FIRST MADE OR DEEMED MADE AGAINST THE "INSUREDS" DURING THE POLICY PERIOD.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

**NOTICE TO MAINE AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.**

**NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.**

**NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.**

**NOTICE TO NEW MEXICO APPLICANTS: 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 CIVIL FINES AND CRIMINAL PENALTIES.**

**NOTICE TO NEW YORK APPLICANTS: 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 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.**

**NOTICE TO OKLAHOMA APPLICANTS: 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.**

**NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.**

**NOTICE TO PENNSYLVANIA APPLICANTS: 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.**

APPLICANT		
BY ( <i>President and/or Executive Director</i> )	TITLE	DATE

Note: This Application must be signed by the President and/or Executive Director of the **Applicant** acting as the authorized agent of the person(s) and entity(ies) proposed for this insurance.

**REQUIRED INFORMATION**

PRODUCED BY ( <i>Insurance Agent</i> ) Please print and sign name  _____ _____		
INSURANCE AGENCY		
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.	
ADDRESS ( <i>No., Street, City, State, and ZIP</i> )		
EMAIL ADDRESS		
SUBMITTED BY ( <i>Insurance Agency</i> )	INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS ( <i>No., Street, City, State, and ZIP</i> )		