



THIS APPLICATION IS FOR A CLAIMS-MADE POLICY. "CLAIMS" MUST BE FIRST MADE AGAINST AN "INSURED PERSON" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTING PERIOD, AND REPORTED TO US AS SOON AS PRACTICABLE DURING THE "POLICY PERIOD," ANY SUBSEQUENT RENEWAL OF THE POLICY OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE INSURANCE FOR WHICH THIS APPLICATION IS MADE APPLIES ONLY IF THE "WRONGFUL ACT" OUT OF WHICH THE "CLAIM" AROSE OCCURRED ON OR AFTER THE RETROACTIVE DATE, IF ANY, SHOWN IN THE DECLARATIONS, AND BEFORE THE END OF THE "POLICY PERIOD."

MANAGEMENT LIABILITY APPLICATION FOR PROFIT AND NOT-FOR-PROFIT ORGANIZATIONS

Please review the policy carefully and discuss the coverage with your insurance advisor.

Please answer all questions completely. If there is insufficient space to complete an answer, please continue on a separate sheet indicating the question number. This Application must be completed, signed, and dated by a president, officer, director or equivalent executive of the Organization. Please include all attachments referenced throughout the Application and complete any supplemental pieces referenced within the Application. Please type or print.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Insurer under any Policy of a Claim or potential Claim. All such notices must be submitted to the Insurer pursuant to the terms of the Policy, if and when issued.

A. GENERAL INFORMATION SECTION

- 1) Name of applicant: _____
- 2) Mailing address: _____
(street) (city) (county) (state) (zip code)
- 3) Telephone number: (____)_____ Fax number: (____)_____
- 4) E-mail address: _____ Web site address: _____
- 5) Contact name: _____
- 6) Is your organization organized under the not-for-profit status of the Internal Revenue Code? ☐ Yes ☐ No
If yes, under what section of the Internal Revenue Code is the named organization so qualified: _____
Has there been or is there now pending any dispute as to the named organization's
tax-exempt status? ☐ Yes ☐ No. If yes, please provide details: _____

- 7) Type of Entity: (Individual, Partnership, Joint Venture, Corporation, Other) _____
- 8) Please indicate how your organization is chartered or incorporated and the original date filed:
_____ / ____ / ____.
- 9) Date Applicant was organized: ____ / ____ / ____ . Has the organization operated continuously from
this date? ☐ Yes ☐ No. If no, please explain: _____

- 10) Description of operations: _____

- 11) Describe duties of owner(s): _____



12) Number of years under current management? _____

13) Number of years of management experience? _____

B. POLICY INFORMATION

- 1) Limit of Liability Desired: ☐ \$1,000,000 ☐ \$2,000,000 ☐ \$3,000,000 ☐ Other \$ _____
- 2) Total budget for last fiscal year: \$ _____ (Please attach a copy of your latest audited financial statement and organizational chart including any cross holdings.)
- 3) Did your organization purchase Directors & Officers Liability Coverage in the past? ☐ Yes ☐ No (If "yes," please provide the following.):
 - a) Name of D&O insurer: _____
 - b) Policy expiration date: _____
 - c) Retroactive date: _____
 - d) Limits of liability: \$ _____ wrongful act; \$ _____ aggregate
 - e) Self-insured retention or deductible: \$ _____
- 4) Does the organization carry General Liability insurance? ☐ Yes ☐ No
- 5) Has any insurer ever refused to renew or cancel your Directors & Officers Liability coverage?
☐ Yes ☐ No (If "yes," please provide reason.) Missouri Applicants are not required to reply.

C. OPERATIONS & EXPOSURE INFORMATION

- 1) Provide the total number of Employees: full time _____ part time _____ temporary _____
- 2) Provide the total number of Volunteers: _____
- 3) Total Number of Locations: _____ Are all locations in the same state? ☐ Yes ☐ No
If No, please list locations by State including Employees per location:
Location# _____ Address: _____
of Employees: full time _____ part time _____ volunteers _____
Location# _____ Address: _____
of Employees: full time _____ part time _____ volunteers _____
Location# _____ Address: _____
of Employees: full time _____ part time _____ volunteers _____
- 4) Provide the total number of Directors/ Trustees and Officers proposed for this insurance:
Directors/ Trustees _____ Officers _____
- 5) Has either your executive director or majority stockholders previously managed a similar organization under another corporate name within the last five years?
☐ Yes ☐ No (If "yes," list the names and dates of the organizations which were managed.)



6) Does the board of directors have at least 51% participation by directors not employed by your organization ? ☐ Yes ☐ No

7) Does the Board have a full-time chairman? ☐ Yes ☐ No

8) Has your organization merged with any other facilities or business enterprises within the past ten years?
☐ Yes ☐ No (If "yes," list the names and dates of the organization with which your operations have merged).

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Engage in any form of research, development, experimentation or testing? ☐ Yes ☐ No.

If yes, please provide details: _____

Conduct peer reviews or assess the qualifications and performance of others or the quality of products manufactured, sold, handled or distributed by others? ☐ Yes ☐ No.

If yes, please provide details: _____

Sponsor any insurance programs? ☐ Yes ☐ No

If yes, please provide details: _____

Publish any magazines, periodicals or newsletters? ☐ Yes ☐ No.

If yes, please provide details and samples: _____

Publish a technical manual? ☐ Yes ☐ No.

If yes, please provide a brief explanation of the purpose of such manual(s): _____

21) Does the organization have involvement in accreditation or standard setting activities? ☐ Yes ☐ No

If yes, please provide details: _____

22) Has the organization closed any facilities, reduced staff, or laid off any employees during the last 3 years? ☐ Yes ☐ No. If yes, please state the reason for the action and identify the number of employees affected by the action: _____

23) Does the organization anticipate closing any facilities, reducing staff, or laying off any employees during the next 2 years? ☐ Yes ☐ No. If yes, please state the reason for the action and identify the number of employees affected by the action: _____

24) Has the named organization or any of its directors, officers, or other proposed "insureds" been a part of any civil or criminal litigation or arbitration proceeding related to the applicant's activities? ☐ Yes ☐ No. (If "yes," please provide complete details on a separate sheet of paper and attach to this application.)

25) Has the named organization or any of its officers, directors or other proposed "insureds" been advised that he, she, or it is the subject of a complaint, suit, inquiry, investigation or other regulatory or judicial proceeding by any governmental or self-regulatory entity? ☐ Yes ☐ No (If "yes," please provide complete details on a separate sheet of paper and attach to this application.)

26) Is any director or officer of your organization aware of any fact or circumstance that he or she has reason to believe might give rise to a claim against any proposed "insured" that could fall within the scope of the proposed coverage? ☐ Yes ☐ No (If "yes," please provide complete details on a separate sheet of paper and attach to this application.)



D. EMPLOYMENT PRACTICES

- 1) Percentage of total employees that are: at will _____% contract _____%
union employees: _____%
- 2) Are all union employees subject to collective bargaining? ☐ Yes ☐ No. (If "yes", please indicate when the last collective bargaining agreement was signed? _____)
- 3) Are you currently or have you in the last five years been subject to any collective bargaining agreements?
☐ Yes ☐ No (If "yes," please describe.)

- 4) Annual employee turnover for each of the last three years: _____ Latest Yr. _____ Second Yr. _____ Third Yr.
- 5) Percentage of employees with length of service longer than one year: _____% Longer than five years
_____%
- 6) Number of employees including executive officers and directors by salary range:
\$25,000 or less _____. \$25,000 - \$75,000 _____. \$75,000-\$150,000 _____ Greater than \$150,000 _____
- 7) How many employees have been terminated or laid off in the past three years? _____
- 8) Do you have an Employment Application for hiring? ☐ Yes ☐ No (If "yes," please attach a copy.)
- 9) Do you publish an employee handbook? ☐ Yes ☐ No If "yes," is it distributed to all employees? ☐ Yes ☐ No
- 10) Do you provide written performance evaluations for all employees? ☐ Yes ☐ No.
If "yes," how frequently? ☐ biannually ☐ annually ☐ every second year (Please attach a copy of the form.)
- 11) Do you have a written, progressive disciplinary program? ☐ Yes ☐ No (If "yes," please attach a copy.)
- 12) Do you have a written grievance program? ☐ Yes ☐ No (If "yes," please attach a copy.)
- 13) Do you uniformly perform comprehensive background checks for screening all employment applicants?
☐ Yes ☐ No. Are volunteers subject to the same background checks? ☐ Yes ☐ No
- 14) Does the employment background check include drug or alcohol screening? ☐ Yes ☐ No
- 15) Has the organization established an affirmative action program? ☐ Yes ☐ No
- 16) Do you have a written anti-sexual harassment policy? ☐ Yes ☐ No If "yes," is it distributed annually to all employees? ☐ Yes ☐ No
- 17) Do you have a separate human resources or personnel department? ☐ Yes ☐ No (If "no," how is this function handled?)



- 18) Do you have a formal orientation program for new employees? ☐ Yes ☐ No
- 19) Are all managers and employees in supervisory positions provided Human Resource training with regard to promulgated policies and procedures? ☐ Yes ☐ No
- 20) Has a specific individual within your organization been assigned the responsibility of receiving and reporting "incident" reports and loss information? ☐ Yes ☐ No
- 21) Do you have a formal out-placement program which assists terminated or laid-off employees searching for other employment? ☐ Yes ☐ No (If "yes," please describe.)
- _____
- _____
- _____
- 22) Do you have an Employee Assistance Program (EAP)? ☐ Yes ☐ No (If "yes," please describe.)
- _____
- _____
- _____
- 23) Do you seek counsel from a human resource person or attorney prior to terminating an employee?
☐ Yes ☐ No
- 24) Do you have outside counsel review your employment handbook? ☐ Yes ☐ No
- 25) Describe your policy for handling requests for references on past employees.
- _____
- _____
- _____
- 26) Has your organization been involved in any grievance or other administrative hearing before a National Labor Relations Board, Equal Employment Opportunity Commission, Federal Labor Standards, Fair Labor Standards, Civil Rights Commission, Department of Labor or any governmental agency within the last five years? ☐ Yes ☐ No (If "yes," please provide specific details including dates, damages incurred, legal expenses, current status and description of the circumstances on a separate sheet of paper and attach to this application.)
- 27) Do you anticipate a reduction of employees over the next year? ☐ Yes ☐ No (If "yes," please provide reason.)
- _____
- If "yes", has the anticipated reduction been explained to employees and/or union representatives? _____
- 28) Are there any outstanding circumstances which may result in a claim of wrongful termination, sexual harassment or discrimination against your organization or any of its directors, officers or employees? ☐ Yes ☐ No (If "yes," fully describe events and details on a separate sheet of paper and attach to this application.)
- 29) Publishers Liability Exposure: Please complete the Publishers Supplemental application attached to and forming a part of this D&O application.



Patriot National Underwriters, Inc.

P.O. Box 803143 • Dallas, TX 75380
800 291-6846 • 972 239-1458 • Fax 972 233-3487
www.patriotnational.com

False Information:

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.

Declaration and Signature:

NOTICE TO APPLICANT - PLEASE READ CAREFULLY

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED, AS AUTHORIZED AGENT FOR ALL PERSONS AND ENTITIES PROPOSED FOR THIS INSURANCE, DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION TO PURCHASE, ANY INSURANCE POLICY.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE INSURER. THIS APPLICATION WILL BECOME A PART OF SUCH POLICY IF ISSUED. THE INSURER WILL HAVE RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING THIS POLICY. IN THE EVENT THAT THE "APPLICATION" CONTAINS ANY MISREPRESENTATION OR MISSTATEMENT OF A MATERIAL FACT, THIS POLICY SHALL NOT AFFORD COVERAGE TO ANY "INSURED" WHO KNEW OF SUCH MISREPRESENTATION OR MISSTATEMENT.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT MUST NOTIFY THE INSURER, WHO MAY MODIFY OR WITHDRAW THE QUOTATION.

THE UNDERSIGNED DECLARES THAT THE INDIVIDUALS AND ORGANIZATIONS PROPOSED FOR THIS INSURANCE HAVE BEEN NOTIFIED THAT:

- A. THIS POLICY APPLIES ONLY TO "CLAIMS" FIRST MADE OR DEEMED MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR EXTENDED REPORTING PERIOD, IF EXERCISED; AND
- B. THE LIMIT OF LIABILITY IS REDUCED BY AMOUNTS INCURRED AS "CLAIMS EXPENSES" AND SUCH EXPENSES WILL BE SUBJECT TO THE RETENTION AMOUNT.

(WORDS WITHIN QUOTATION MARKS ARE DEFINED IN THE INSURANCE POLICY.)

Printed Name of Chairman of the Board or Chief Executive Officer

Signature of Chairman of the Board or Chief Executive Officer

Title

Date

INSURANCE AGENT INFORMATION:

Agency name: _____

Contact person: _____

Agency address: _____

Telephone number: _____ Fax number: _____

E-mail address: _____



**SCHEDULE OF DIRECTORS & OFFICERS
DIRECTORS, OFFICERS OF THE ORGANIZATION**

Name	Title/Position	Occupation

DIRECTORS, OFFICERS OF SUBSIDIARY ORGANIZATIONS

Subsidiary Name	Director/Officer	Title/Position	Occupation

DIRECTORS, OFFICERS OF NON-RELATED FOR PROFIT ORGANIZATIONS

For Profit Organization Name	Director/Officer	Title/Position



APPLICATION FOR FIDUCIARY LIABILITY COVERAGE PART

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SECTION I - GENERAL INFORMATION	
Named Organization (Applicant):	
Mailing Address:	
Phone Number:	Fax Number:
Web Site:	E-Mail Address:
State Of Incorporation (if applicable):	Date Of Incorporation (if applicable):
Federal Employer Identification Number (FEIN):	Nature Of Business:
Enter Standard Industrial Code (SIC) Or North American Industry Classification System (NAICS) Code:	

SECTION II - FORM OF ORGANIZATION										
Type Of Business:										
<table><tbody><tr><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> Corporation</td></tr><tr><td><input type="checkbox"/> Joint Venture</td><td><input type="checkbox"/> LLC</td><td></td></tr><tr><td colspan="3"><input type="checkbox"/> Other (Please describe):</td></tr></tbody></table>		<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	<input type="checkbox"/> Joint Venture	<input type="checkbox"/> LLC		<input type="checkbox"/> Other (Please describe):		
<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation								
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> LLC									
<input type="checkbox"/> Other (Please describe):										
Has the Applicant been involved in any merger, consolidation or acquisition with any other organization within the last three years?										
Yes <input type="checkbox"/> No <input type="checkbox"/>										

SECTION III – COVERAGE REQUESTED	
A. Limit Of Liability: \$	
B. Retention Amount: \$	C. Policy Period From: To:

SECTION IV – LIST OF PLANS FOR WHICH COVERAGE IS REQUESTED				
Type*	Name Of Plan	Total Assets	Trustee/Plan Administrator	No. Of Participants
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		
Total Assets of all plans: \$		Total no. of participants for all plans:		
*Type: DB = Defined Benefit, DC = Defined Contribution, E = ESOP, P = Pension, W = Welfare, O = Other				
<div style="display: flex; justify-content: space-between;"> <div> <p>1. Are all plans in compliance with regard to eligibility, participation, vesting and funding of the Employee Retirement Security Act of 1974 (ERISA) or any other similar law?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If No, please explain:</p> </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div> <p>2. Does any plan currently have a funding deficiency?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes, please explain:</p> </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div> <p>3. Are the Defined Benefit plans adequately funded as attested to by an actuary?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If No, please explain:</p> </div> </div>				

<p>4. Is the Applicant delinquent in contributing to any plan? If Yes, please indicate which plans and provide details:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>5. Is any plan invested in employer securities? If Yes, please indicate which plans:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>6. Is any plan a multiple employer plan? If Yes, please indicate which plans:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>7. In the past three years, has any plan been consolidated or merged with another plan? If Yes, please indicate which plans:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>8. Has any plan or portion of any plan for which coverage is requested been sold, transferred or terminated? If Yes, please provide details:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>9. In the past three years, has any plan experienced a reduction in benefits? If Yes, please indicate which plans:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>10. In the past three years, has any plan applied for approval of a plan amendment? If Yes, please indicate which plans:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>11. Does the Applicant plan on terminating, suspending or merging any plans within the next 12 months? If Yes, please indicate which plans and provide details:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

12. Is there an ERISA fidelity bond coverage currently in force with another insurer for all the plans proposed for coverage?

Yes ☐ No ☐

If Yes, please provide details below:

Insurer	Limit	Premium
	\$	\$

13. If any plan is an Employee Stock Ownership Plan, please provide the following information:

a. Plan Name:

b. Date that the Plan was established :

c. Percentage of the Employer Sponsor's common stock held by the Plan:

d. Is the stock publicly traded on an exchange?

Yes ☐ No ☐

e. If the answer to d. is No, how is the stock valued and how often is it valued? Provide details below:

f. Is an acquisition loan currently being paid off?

Yes ☐ No ☐

g. If the answer to f. is Yes, please provide the original amount of the loan and the loan's outstanding balance below:

(1) Original amount of loan: \$

(2) Outstanding balance of loan: \$

SECTION V – PAST ACTIVITIES

1. Within the last three years, has the Applicant, any subsidiary of the Applicant, any past or present Director, Officer, Employee or Trustee, or any past or present person or entity acting as fiduciary, been involved in a claim or suit regarding the violation of ERISA or any similar law?

Yes ☐ No ☐

If Yes, please explain:

2. Within the last three years, has the Applicant, any subsidiary of the Applicant, any past or present Director, Officer, Employee or Trustee, or any past or present person or entity acting as fiduciary, been involved in any inquiry or investigation or received a communication regarding the violation of ERISA or any similar law?

Yes ☐ No ☐

If Yes, please explain:

3. Does the Director, Officer, or Trustee know of any fact, circumstance or situation involving the violation of ERISA or any similar law by the Applicant, any subsidiary of the Applicant, any past or present Director, Officer, Employee or Trustee, or any past or present person or entity acting as fiduciary that could give rise to a future claim or suit?

Yes ☐ No ☐

If Yes, please explain:

It is understood and agreed that if any such claim exists, or any such facts or circumstances exist which could give rise to a claim, then those claims and any other claims arising from such facts or circumstances are excluded from the proposed coverage.

SECTION VI – PLAN MANAGEMENT

1. Are any Directors, Officers or Employees of the Applicant trustees of any of the plans?

Yes ☐ No ☐

If Yes, please provide names of persons and plan(s):

Name Of Director, Officer Or Employee	Name Of Plan(s)

2. Does any plan employ outside consulting services such as investment, actuarial, accounting, legal or administrative services?

Yes ☐ No ☐

If Yes, please provide a complete description of the services, name of consultant and name of plan(s):

Description Of Services	Name Of Consultant	Name Of Plan(s)

SECTION VII – PRIOR INSURANCE

1. Has the Applicant previously held, or does it now have, any Fiduciary Liability coverage or any similar insurance?

Yes ☐ No ☐

If Yes, please provide the following details:

Name Of Insurer:

Policy Period

From:

To:

Limit Of Liability: \$

Retention: \$

Premium: \$

Name Of Insurer:

Policy Period

From:

To:

Limit Of Liability: \$

Retention: \$

Premium: \$

Name Of Insurer:

Policy Period

From:

To:

Limit Of Liability: \$

Retention: \$

Premium: \$

2. Has any insurance been cancelled or nonrenewed in the past 5 years?

If Yes, please provide the reason for cancellation or nonrenewal:

Yes ☐ No ☐

SECTION VIII – ADDITIONAL REQUIRED APPLICATION MATERIALS

As attachments to this Application, please include the following (where applicable):

- Most recent Form 5500(s), including Schedule B
- CPA-audited report for each plan
- Actuarial report for each plan
- Most recent Annual Report
- Latest available interim financial statements

NOTICE TO APPLICANT – PLEASE READ CAREFULLY

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED OFFICER OF THE NAMED ORGANIZATION DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO ISSUE, OR THE APPLICANT TO PURCHASE, ANY INSURANCE POLICY.

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(WORDS WITHIN QUOTATION MARKS ARE DEFINED IN THE INSURANCE POLICY.)

NOTE:

This Application must be signed by the Chairman and/or President of the Named Organization acting as the authorized Agent of the Applicant applying for this insurance.

Printed Name of Chairman and/or President:

Signature of Chairman and/or President:

Title:

Date: