



# Not-for-Profit Management Liability Application

Insured Persons & Organization Liability, Employment Practices Liability, and Fiduciary Liability

## I. GENERAL APPLICANT INFORMATION:

Applicant's Name \_\_\_\_\_  
 Location Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Website \_\_\_\_\_ Mailing Address (if different than location) \_\_\_\_\_  
 Officer Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

## II. GENERAL UNDERWRITING INFORMATION & ELIGIBILITY:

1. Description of Operations \_\_\_\_\_
2. Annual Revenue \$ \_\_\_\_\_
3. Fund balance (Total Assets – Total Liabilities) \$ \_\_\_\_\_
4. Employee Count

Full Time	Part Time	Seasonal/Temporary	Volunteer

5. Date of Incorporation \_\_\_\_\_

*\*If any questions below are answered yes, please provide details on a separate attachment.*

6. Does the proposed **Insured** offer services to individuals under the age of 18? Yes  No
7. Does the proposed **Insured** offer a Professional Service? Yes  No
8. Does the proposed **Insured** have plans for or have there been mergers/acquisitions/down-sizing (within the past or future 12 months)? Yes  No
9. Does the proposed **Insured** have a Subsidiary(s)/Affiliated Entity(s)? Yes  No 
  - a. If yes, is the proposed **Insured** seeking coverage for the Entity(s)? Yes  No
10. Has the proposed **Insured's** insurance been non-renewed or cancelled (within the past 5 years)? Yes  No
11. Is the proposed **Insured** currently or anticipating bringing litigation? Yes  No

## III. PRIOR INSURANCE INFORMATION:

Describe any current insurance maintained.

Coverage	Yes	No	Limits	Continuity Date	Expiring Premium
Insured Persons and Organization Liability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Employment Practices Liability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Fiduciary Liability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

## IV. CLAIMS INFORMATION:

1. Has there been, or is there now pending, any **Claims(s)** against any proposed **Insured**? Yes  No
2. Does any proposed **Insured** have knowledge or information of any act, error, omission, fact, circumstance, inquiry or investigation which might give rise to a **Claim** under the proposed **Policy**? Yes  No
3. During the last 5 years have any of the **Insureds** been involved in any administrative proceedings before the Equal Employment Opportunity Commission, the U.S. Department of Labor, including the Office of Federal Contract Compliance Programs, or any state or local government agency whose purpose is to address employment-related claims? Yes  No
4. Have any **Insureds** ever been the subject of a disciplinary action or required to comply with any judicial or administrative agreement, order, decree or judgment? Yes  No

## V. FIDUCIARY LIABILITY INFORMATION:

1. Indicate the type of plans to be insured:  
 Welfare Benefit     Pension     Profit Sharing     Other \_\_\_\_\_



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2. Do all of the plans conform to the standards of eligibility, participation, vesting and other provisions of the Employee Retirement Income Security Act of 1974, as amended? Yes  No
3. Are any of the plans underfunded? Yes  No
4. Are any of the plans a multi-employer plan? Yes  No

### NOTICE TO ALL APPLICANTS:

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

### NOTICE TO APPLICANTS. PLEASE READ CAREFULLY

BY SIGNING THIS APPLICATION, THE APPLICANT, ON BEHALF OF ALL PROPOSED INSURED, REPRESENTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ATTACHMENTS HERETO ABOUT THE APPLICANT, ITS SUBSIDIARIES, AND THEIR OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED, OMITTED, SUPPRESSED, CONCEALED, OR MISREPRESENTED IN THIS APPLICATION OR ITS ATTACHMENTS. THE APPLICANT UNDERSTANDS AND AGREES THAT IF, AFTER THE DATE OF THIS APPLICATION AND PRIOR TO THE EFFECTIVE DATE OF ANY POLICY BASED ON THIS APPLICATION AND ATTACHMENTS, ANY OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE INSURANCE MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT UNDERSTANDS AND AGREES THAT THE COMPANY, IN PROPOSING TO PROVIDE INSURANCE, HAS RELIED ON THIS APPLICATION AND ALL ATTACHMENTS, AND THAT THIS APPLICATION AND ALL ATTACHMENTS ARE (1) MATERIAL AND THE BASIS OF THE CONTRACT WITH THE COMPANY, AND (2) DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

THE UNDERSIGNED OFFICER OF THE APPLICANT CERTIFIES AND REPRESENTS THAT HE/SHE IS DULY AUTHORIZED TO EXECUTE THIS APPLICATION ON BEHALF OF THE APPLICANT AND ITS SUBSIDIARIES.

### Applicant's Signature:

\_\_\_\_\_  
(Must be signed by an Officer or Executive Director of the Applicant)

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (Mo./Day/Yr.)