

APPLICATION FOR FIDUCIARY LIABILITY INSURANCE COVERAGE

NOTICE: THE POLICY WHICH YOU ARE APPLYING IS A CLAIMS-MADE POLICY. THE POLICY COVERS ONLY CLAIMS FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR, IF ELECTED, THE EXTENDED REPORTING PERIOD, SUBJECT TO THE POLICY PROVISIONS. DEFENSE COSTS ARE APPLIED AGAINST THE APPLICABLE RETENTIONS. DEFENSE COSTS REDUCE AND MAY EXHAUST THE APPLICABLE LIMITS OF LIABILITY. THE INSURER IS NOT LIABLE FOR ANY LOSS, WHICH INCLUDES DEFENSE COSTS, IN EXCESS OF THE APPLICABLE LIMITS OF LIABILITY.

1. Name of Applicant: _____
 (Whenever used in this Application, the term "Applicant" shall mean the **Named Insured**.)
- Address: _____
- City: _____ State: _____ Zip Code: _____
- State of Incorporation: _____ Date of Incorporation: _____
- Website Address: _____

2. Applicant's primary nature of business: _____
- _____

3. Please complete the following table; please attach a schedule if necessary:

Plan Name	Plan Type*	# Participants	Plan Assets	Plan Status

*Plan Type: Health & Welfare Plan: HWP; Defined Contribution Plan: DCP; Defined Benefit Plan: DBP; Employee Stock Ownership Plan: ESOP; Excess Benefit Plan: EBP; Other: Please explain by attachment.

4. Does each Plan conform to ERISA and Plan Agreements? Y/N
5. Are any of the defined benefit plans for which coverage is being requested under-funded by more than 10%? Y/N N/A
 If yes, by what percentage is the plan under-funded? _____%
6. Do any of the Plans hold or provide the option to invest in securities of the company or any subsidiary? Y/N
 If yes, please list the percentage of the Plan's total assets that the company's securities comprise. _____%
7. During the past two years have there been, or in the next twelve months do you anticipate any reduction in benefits? Y/N
8. During the past two years have there been, or in the next twelve months do you anticipate freezing any defined benefit plan or converting it to a cash balance plan? Y/N
9. Does any Defined Benefit Plan above (if applicable) have a funding deficiency? Y/N
 If yes, please provide details by attachment.
10. Has any Plan been the subject of an investigation by the DOL, IRS or similar foreign regulatory agency in the past twelve months? If yes, please provide details by attachment. Y/N

11. Have there been any acquired or merged plans in the past twelve months? If yes, please provide details by attachment.

12. Does the Applicant utilize outside consultants to manage or control any plan assets? Y/N
If yes, please provide details by attachment.

13. Does the employer match contributions to the 401k plan (if applicable) with employer securities? Y/N

14. Has any plan filed for an exemption to a prohibited transaction? Y/N
If yes, please provide details by attachment.

15. Are there restrictions on the disposition of company stock held in any plan? Y/N
If yes, please provide details by attachment.

16. Please provide the following information on insurance currently maintained by the Applicant:

Coverage	Insurer	Limit	Retention	Premium	Policy Period
Fiduciary Liability					

LOSS/CLAIMS HISTORY

17. Have any claims such as would fall within the scope of the proposed insurance been made against any person(s) or entity(ies) proposed for this insurance? Y/N

If "Yes", please attach complete details.

PRIOR KNOWLEDGE

18. Does the Applicant or any individual or entity proposed for coverage have any knowledge of or information about any actual or alleged act, error, omission, fact or circumstance which may give rise to a claim that may fall within the scope of the proposed insurance? Y/N

If "Yes", please attach complete details.

WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE INSURER, IT IS UNDERSTOOD AND AGREED THAT IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM ARISING THEREFROM IS EXCLUDED FROM THIS PROPOSED INSURANCE.

ADDITIONAL INFORMATION

As part of this Application, please submit the following documents with respect to the **Applicant**:

- a) Audited financial statements with any notes and schedules for the **Applicant**.
- b) Copy of the latest form 5500s and audited financial statements for each of the **Applicant's** employee benefit plans (excluding any Welfare Benefit Plan).
- c) Summary and status of any litigation filed within the last twelve (12) months against any person(s) or entity(ies) proposed for this insurance (including any litigation that has been resolved).

NOTICE:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE GUILTY OF COMMITTING A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT FRAUD WARNINGS

ALABAMA, ARKANSAS, LOUISIANA, MARYLAND, NEW JERSEY, NEW MEXICO and VIRGINIA: 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. In Alabama, Arkansas, Louisiana and Maryland, that person may be subject to fines, imprisonment or both. In New Mexico, that person may be subject to civil fines and criminal penalties. In Virginia, penalties may include imprisonment, fines and denial of insurance benefits.

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.

DISTRICT OF COLUMBIA, KENTUCKY 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 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. In District of Columbia, penalties include imprisonment and/or fines. In addition, the Insurer may deny insurance benefits if the Applicant provides false information materially related to a claim. In Pennsylvania, the person may also be subject to criminal and civil penalties.

FLORIDA and OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive the Insurer, files a statement of claim or an Application containing any false, incomplete or misleading information is guilty of a felony. In Florida it is a felony to the third degree.

KANSAS: An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an Insurer, purported Insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for personal or commercial insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto is considered a crime.

MAINE: 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 denial of insurance benefits.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against the Insurer, submits an Application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OREGON: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE 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 may include imprisonment, fines and/or denial of insurance benefits.

THE SIGNATORY, AS AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE, REPRESENTS THAT, TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS IN THIS APPLICATION AND ANY ATTACHMENTS OR INFORMATION SUBMITTED WITH THIS APPLICATION (TOGETHER REFERRED TO AS THE "APPLICATION") ARE TRUE AND COMPLETE.

THE INFORMATION IN THIS APPLICATION IS MATERIAL TO THE RISK ACCEPTED BY THE UNDERWRITER. IF A POLICY IS ISSUED IT WILL BE IN RELIANCE BY THE UNDERWRITER UPON THE APPLICATION, AND THE APPLICATION WILL BE THE BASIS OF THE



CONTRACT. THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE UNDERWRITER AND, ALONG WITH THE APPLICATION, WILL BE CONSIDERED PHYSICALLY ATTACHED TO, PART OF, AND INCORPORATED INTO THE POLICY, IF ISSUED. THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. THE UNDERWRITER'S ACCEPTANCE OF THIS APPLICATION OR THE MAKING OF ANY SUBSEQUENT INQUIRY DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE OR ISSUE A POLICY.

THE INFORMATION PROVIDED IN THIS APPLICATION IS FOR UNDERWRITING PURPOSES ONLY AND DOES NOT CONSTITUTE NOTICE TO THE UNDERWRITER UNDER ANY POLICY OF A CLAIM OR POTENTIAL CLAIM.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL IMMEDIATELY NOTIFY THE UNDERWRITER, AND THE UNDERWRITER MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

SIGNATURE

THIS APPLICATION MUST BE SIGNED BY THE CHAIRMAN OF THE BOARD, CHIEF EXECUTIVE OFFICER OR THE PRESIDENT OF THE COMPANY ACTING AS THE AUTHORIZED REPRESENTATIVE OF THE PERSONS AND ENTITIES PROPOSED FOR THIS INSURANCE.

SIGNATURE

TITLE

DATE