



AGENCY CUSTOMER ID: _____

FIDUCIARY LIABILITY COVERAGE SECTION

DATE (MM/DD/YYYY)

AGENCY	APPLICANT / FIRST NAMED INSURED	
POLICY NUMBER	CARRIER	NAIC CODE
* REQUESTED EFFECTIVE DATE:	* EXPIRATION DATE:	

COVERAGE REQUESTED

* 12:01 AM at the Principal Address of the Applicant

PLEASE ATTACH A COPY OF THE FOLLOWING:

- COPY OF THE MOST RECENTLY FILED FORM 5500s FOR ALL ERISA PLANS EXCEPT HEALTH AND WELFARE PLANS
- AUDITED FINANCIAL STATEMENTS WITH INVESTMENT PORTFOLIOS FOR THE FIVE LARGEST EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) PLANS EXCEPT HEALTH AND WELFARE PLANS
- THE LATEST ANNUAL REPORT OF THE APPLICANT, INCLUDING AUDITED FINANCIAL STATEMENTS
- PLAN DESCRIPTION AND FINANCIAL STATEMENTS, IF APPLICABLE FOR ANY NON-QUALIFIED PLANS

PRIMARY	EXCESS	REQUESTED LIMITS	CURRENT LIMITS	RETENTION	ANNUAL PREMIUM
<input type="checkbox"/>	<input type="checkbox"/>	PER CLAIM: \$	PER CLAIM: \$	REQ: \$	\$
		AGGR: \$	AGGR: \$	CURR: \$	
SEPARATE DEFENSE COSTS LIMIT <input type="checkbox"/> (Y / N) \$		DEFENSE LIMIT <input type="checkbox"/> INSIDE <input type="checkbox"/> OUTSIDE		PENDING & PRIOR LITIGATION DATE:	

SHARED LIMITS (Y / N) **ADDITIONAL COVERAGES ATTACHED** (Y / N)

INDICATE SECTIONS INCLUDED					
<input type="checkbox"/> D&O LIABILITY	<input type="checkbox"/> CRIME	<input type="checkbox"/> FIDUCIARY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> EPLI	<input type="checkbox"/> PROF LIABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ENDORSEMENTS

	FORM NUMBER (For Insurer Use Only)	TITLE	EDITION DATE
SPECIMEN			

PLAN INFORMATION (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

PLAN NAME	YEAR ESTABLISHED	TYPE OF PLAN	PLAN ASSETS CURRENT YEAR	PLAN ASSETS PRIOR YEAR	TOTAL CURRENT PLAN PARTICIPANTS
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
TOTAL ASSETS:			\$	\$	

TYPE OF PLAN CODES

HWP - HEALTH AND WELFARE PLAN DBP - DEFINED BENEFIT PLAN ESOP - EMPLOYEE STOCK OWNERSHIP PLAN
 DCP - DEFINED CONTRIBUTION PLAN CB - CASH BALANCE EBP - EXCESS BENEFIT PLAN OR TOP HAT PLAN OTHER (Describe):

REMARKS

PLAN ADMINISTRATION

1. DOES APPLICANT DELEGATE AUTHORITY OF THE MANAGEMENT AND CONTROL OF ANY PLAN'S ASSETS TO ANY OUTSIDE CONSULTANT(S)? Y / N
 If "YES", please provide the following information with respect to each plan (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

INVESTMENT ADVISOR NAME	ADDRESS	YEARS EMPLOYED
ACTUARY NAME	ADDRESS	YEARS EMPLOYED
LEGAL COUNSEL NAME	ADDRESS	YEARS EMPLOYED
CPA NAME	ADDRESS	YEARS EMPLOYED
ADMINISTRATOR NAME	ADDRESS	YEARS EMPLOYED
OTHER: NAME	ADDRESS	YEARS EMPLOYED
OTHER: NAME	ADDRESS	YEARS EMPLOYED

SPECIMEN

EXPLAIN ALL YES RESPONSES	Y / N
2. DOES APPLICANT HANDLE ANY INVESTMENT DECISIONS IN-HOUSE? (If "YES", describe)	
3. ARE PLAN BENEFITS PROVIDED BY INSURANCE (e.g., annuity, medical policy, etc.) If "YES", provide name of insurance company. INSURANCE COMPANY:	

PLAN CHANGES

EXPLAIN ALL YES RESPONSES	Y / N
1. HAVE THERE BEEN ANY MERGERS OF PLANS IN THE PAST THREE (3) YEARS? (If "YES", describe)	
2. HAS ANY PLAN OR PORTION OF ANY PLAN BEEN SOLD, TRANSFERRED OR TERMINATED IN THE PAST THREE (3) YEARS? (If "YES", provide the date of sale or termination, whether assets have been fully distributed or reverted to a party other than the plan participants and name of annuity provider if benefits have been secured by annuities)	
3. IS ANY CONVERSION TO A CASH BALANCE PLAN BEING CONSIDERED? (If "YES", attach complete details including copies of any descriptive literature distributed to plan participants and descriptions of any grandfather provisions)	
4. FOR EACH CASH BALANCE PLAN, WAS THE PLAN CONVERTED FROM A PRIOR DEFINED BENEFIT (PENSION) PLAN? (If "YES", attach complete details including copies of any descriptive literature distributed to plan participants and descriptions of any grandfather provisions)	

REMARKS

COMPLIANCE

EXPLAIN ALL YES RESPONSES UNLESS INDICATED OTHERWISE	Y / N
1. DO THE PLANS CONFORM TO THE STANDARDS OF ELIGIBILITY, PARTICIPATION, VESTING, FUNDING AND OTHER PROVISIONS OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA), THE PENSION PROTECTION ACT OF 2006, OR SIMILAR FOREIGN LAWS, IF APPLICABLE? (If "NO", explain)	
2. HAVE THE PLANS BEEN REVIEWED TO ASSURE THAT THERE ARE NO VIOLATIONS OF PROHIBITED TRANSACTIONS AND PARTY-IN-INTEREST RULES? (If "NO", explain)	
3. HAS ANY PLAN FILED FOR AN EXEMPTION FROM A PROHIBITED TRANSACTION? (If "YES", attach filing and Department of Labor response)	
4. HAS AN ACTUARY CERTIFIED THAT THE PLANS ARE ADEQUATELY FUNDED? (If "NO", explain)	
5. ARE THERE ANY OUTSTANDING DELINQUENT CONTRIBUTIONS? (If "YES", describe)	
6. HAVE ANY PLANS EXPERIENCED ANY EVENT REPORTABLE TO THE PENSION BENEFIT GUARANTY CORPORATION (PBGC)? (If "YES", describe)	
7. WITHIN THE LAST THREE (3) YEARS HAS ANY PLAN LOANED MONEY TO, OR INVESTED IN, THE SECURITIES OF THE APPLICANT OR ITS AFFILIATES? (If "YES", provide details including percentage of holdings)	

GENERAL INFORMATION

EXPLAIN ALL YES RESPONSES	Y / N
1. HAS ANY FIDUCIARY BEEN ACCUSED, FOUND GUILTY OR HELD LIABLE FOR A BREACH OF TRUST? (If "YES", attach details)	
2. HAS ANY FIDUCIARY BEEN CONVICTED OF CRIMINAL CONDUCT? (If "YES", attach details)	
3. HAS THERE BEEN ANY ASSESSMENT OF FEES, FINES OR PENALTIES UNDER ANY VOLUNTARY COMPLIANCE RESOLUTION PROGRAM OR SIMILAR VOLUNTARY SETTLEMENT PROGRAM ADMINISTERED BY THE IRS, DOL OR OTHER GOVERNMENT AUTHORITY AGAINST ANY PLAN? (If "YES", describe)	
4. DURING THE LAST FIVE (5) YEARS HAS THE APPLICANT OR ANY OTHER PROPOSED INSURED BEEN INVOLVED IN ANY CLAIMS, LAWSUITS OR ADMINISTRATIVE PROCEEDINGS?	
5. ARE ANY PERSONS OR ENTITIES PROPOSED FOR THIS INSURANCE, AWARE OF ANY FACT, CIRCUMSTANCE, ACT, ERROR, OMISSION OR SITUATION WHICH MAY GIVE RISE TO A CLAIM THAT WOULD FALL WITHIN THE SCOPE OF THE PROPOSED INSURANCE? (If "YES", has the policyholder or any insured individual, given written notice under the provisions of any prior or current insurance policy?)	
6. IS THERE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) FIDUCIARY BOND COVERAGE CURRENTLY IN FORCE? (If "YES", provide name of carrier) NAME OF CARRIER:	

SPECIMEN

REMARKS

REMARKS

AGENCY CUSTOMER ID: _____

COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT. (Not applicable in all states, consult your agent or broker for your state's requirements.)

NOTICE OF INSURANCE INFORMATION PRACTICES - PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT POLICY RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS, IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

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.

IN KANSAS, 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 COMMERCIAL OR PERSONAL 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 COMMITS A FRAUDULENT INSURANCE ACT.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN 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.

IF THERE IS ANY MATERIAL CHANGE IN THE ANSWERS TO THE QUESTIONS IN THIS APPLICATION BEFORE THE POLICY INCEPTION DATE, THE APPLICANT MUST IMMEDIATELY NOTIFY THE COMPANY IN WRITING, AND ANY OUTSTANDING QUOTATION MAY BE MODIFIED OR WITHDRAWN.

I REPRESENT THAT I AM AN AUTHORIZED EMPLOYEE OF THE PROSPECTIVE NAMED INSURED. I ALSO REPRESENT THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS HEREIN WHICH ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT SIGNING THIS APPLICATION SHALL NOT CONSTITUTE A BINDER OR OBLIGATE THE COMPANY TO COMPLETE THIS INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS UPON WHICH A POLICY MAY BE ISSUED.

THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, ITS ATTACHMENTS, AND SUCH OTHER INFORMATION SUBMITTED THEREWITH IN ISSUING ANY POLICY. THE INFORMATION REQUESTED IN THE APPLICATION IS FOR UNDERWRITING PURPOSES ONLY AND DOES NOT CONSTITUTE NOTICE TO THE COMPANY UNDER ANY POLICY OF A CLAIM OR POTENTIAL CLAIM. (Not applicable in North Carolina)

MUST BE SIGNED BY AN EXECUTIVE WHO IS A CURRENT FIDUCIARY OF A SPONSORED PLAN PROPOSED FOR THIS INSURANCE

APPLICANT'S SIGNATURE	APPLICANT'S TITLE	DATE
PRODUCER'S NAME	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER