ERisk Services, LLC®

Northwest Professional Center
227 US Hwy 206, Suite 302
Flanders, NJ 07836-9174
Tel: (973) 252-5141 / (800) 689-2550
Fax: (973) 252-5146 / (800) 689-2839
www.ERiskServices.com
email: application@ERiskServices.com

Application for
Business and Management (BAM)
Indemnity Insurance
Non-Profit Organizations

NOTICE: THE CLAIMS MADE AND REPORTED LIABILITY COVERAGE SECTIONS OR PROVISIONS OF THIS POLICY FOR WHICH THIS APPLICATION IS BEING MADE, WHICHEVER ARE APPLICABLE, COVER ONLY CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR, IF APPLICABLE, ANY DISCOVERY PERIOD AND REPORTED TO THE INSURER PURSUANT TO THE TERMS OF THE POLICY. THE AMOUNTS INCURRED TO DEFEND A CLAIM REDUCE THE APPLICABLE LIMIT OF LIABILITY AND ARE SUBJECT TO THE APPLICABLE RETENTION OR DEDUCTIBLE.

Instructions: Please read carefully and answer all questions. If a question is not applicable, so state. This Application and all exhibits shall be held in confidence. Please read the Policy for which application for coverage is made (the "Policy") prior to completing this Application. The terms as used herein shall have the meanings as defined in the Policy.

Applicant means all organizations or other entities set forth in Question 1. of the **General Information** section of this **Application**, including any subsidiaries, as **Insureds** under the Policy..

I. **General Information**

1. Name of **Applicant**: _____

    Address: _____
                        (Number)   (Street)

                    _____
                        (City)   (State)   (Zip Code)

2. Internal Revenue Service Code: _____

3. Nature of Operations: _____

    _____
    *Note – please include description of all **Applicants**, including any subsidiaries.

4. Website: _____

5. Has the **Applicant** been in business longer than three (3) years?   ❑ Yes ❑ No

6. Is the **Applicant** involved in any labor/union negotiations or collective bargaining activities?   ❑ Yes ❑ No

II. Prior Insurance and Activities Information

1. Describe any current insurance maintained.

Coverage		Limit of Liability	Retention	Premium	Expiration Date
Employment Practices	❑ Yes				
Name of Current Insurer:			Date Coverage First Purchased:		
Insured Person and Organization	❑ Yes				
Name of Current Insurer:			Date Coverage First Purchased:		
Fiduciary	❑ Yes				
Name of Current Insurer:			Date Coverage First Purchased:		

2. Does the **Applicant** carry general liability insurance? ❑ Yes ❑ No

3. Has any insurer made any payments, taken notice of claim or potential claim or non-renewed any management liability or similar insurance at any time in the last three (3) years? If yes, please provide details on a separate page. ❑ Yes ❑ No

4. Within the last three (3) years, has the **Applicant** or any person proposed for this insurance in his or her capacity as an employee, officer, trustee or director of the **Applicant** or another entity been the subject of or involved in any:

    a. litigation, civil, arbitration, administrative or criminal proceeding, civil or criminal charge or hearing, or a written demand seeking monetary or non-monetary damages? ❑ Yes ❑ No

    b. formal or informal investigation, proceeding or inquiry by any federal, state or local governmental agency or regulatory body, including without limitation, the U.S. Department of Justice, the U.S. Department of Labor, or any federal or state office of the Attorney General? ❑ Yes ❑ No

    c. notice of charges or other proceeding from the Equal Employment Opportunity Commission or any similar state or local agency or regulatory body? ❑ Yes ❑ No

If yes, please provide details on a separate page.

III. False Information

FRAUD WARNING: 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. **(Not applicable to Oregon).**

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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.

WARNING TO DISTRICT OF COLUMBIA APPLICANTS: 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.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any in-surer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO LOUISIANA 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 fines and confinement in prison.

NOTICE TO MAINE 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 knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he 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.

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 RHODE ISLAND 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 fines and confinement in prison.

FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON): Any person who intentionally presents a materially false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA 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 include imprisonment, fines, and denial of insurance benefits.

NEW YORK FRAUD WARNING: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

IV. Other Information

1. The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this

Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this application will be attached to and become a part of such Policy, if issued. The Insurer hereby is authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

2. It is represented that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on files by Insurer and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

3. It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the Policy, the **Applicant** will notify the Insurer and, at the sole discretion of Insurer, any outstanding quotations or binders may be modified or withdrawn.

4. It is agreed that in the event of any misstatement, omission, or untruth in this Application or any material submitted along with or contained herein, the Insurer has the right to exclude from coverage any claim based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving such misstatement, omission or untruth.

Signed: _____   Date: _____
       (must be signed by an Executive Officer of the **Applicant**)

For purposes of creating a binding contract of insurance by this application or in determining the rights and obligations under such contract in any court of law, the parties acknowledge that a signature reproduced by either digital signature, electronic signature, facsimile or photocopy shall have the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

Please fully complete and attach the Information for the Coverage Section(s) being sought or bound.

Any coverage part information section(s) of this Application are deemed signed and dated by the signatory in this section IV. of the Application, unless otherwise specifically signed and dated.

V. Employment Practices Coverage Section Information

Is the **Applicant** seeking Employment Practices coverage? If yes, please answer the following questions.   ❑ Yes ❑ No

1. **Employee and employment compensation information:**

Full Time: _____ Part Time: _____ Seasonal: _____ Contracted (leased, independent or otherwise): _____

2. Does the **Applicant** anticipate in the next twelve (12) months, or has the **Applicant** transacted in the last twelve (12) months, any branch or office closings, consolidations or layoffs affecting thirty five percent (35%) or more of the employees of the **Applicant**? If yes, please provide details on a separate page.

     ❑ Yes ❑ No

3. Describe the internal controls the **Applicant** maintains for Employment Practices.

   a. Does the **Applicant** publish and distribute an employee handbook to every employee?   ❑ Yes ❑ No

   b. Are there written procedures for handling employee complaints of discrimination or sexual harassment?   ❑ Yes ❑ No

   c. Are there written procedures for handling employee grievances or complaints?   ❑ Yes ❑ No

VI. Insured Person and Organization Coverage Section Information

Is the **Applicant** seeking Insured Person and Organization coverage? If yes, please answer the following questions.   ❑ Yes ❑ No

1. Describe the following financial information of the **Applicant** for the most recent fiscal year-end.

   a. **Total Assets:** $ _____
   b. Do total liabilities exceed total assets or does the **Applicant** have a negative fund balance? If yes, please provide details on a separate page.   ❑ Yes ❑ No

2. Does the **Applicant** have any taxable subsidiaries generating more than $250,000 in annual revenues? If yes, please provide details on a separate page.   ❑ Yes ❑ No

3. Does the **Applicant**, directly or indirectly render any services for others for a fee or other consideration? If yes, please provide details on a separate page.   ❑ Yes ❑ No

4. Does the **Applicant**, directly or indirectly, fundraise, advocate, solicit, advertise, promote or perform any similar activities for any person, event, cause or other purpose employing any automatic/robo dialing, mobile phone texting, faxing, or any other type of communications based mechanism or strategy governed under the rules and regulations of the Telephone Consumer Protection Act of 1991 (TCPA), as amended? If yes, please provide details on a separate page.   ❑ Yes ❑ No

6. Has the **Applicant**, in any year within the last five (5) years, annually derived more than $250,000 of its revenues or funding from federal, state, local, foreign or other governmental or quasi-governmental sources? If yes, please provide details on a separate page.   ❑ Yes ❑ No

VII. Fiduciary Coverage Section Information

Is the **Applicant** seeking Fiduciary Liability coverage? If yes, please answer the following questions.   ❑ Yes ❑ No

1. **Type of plans to be insured:**   ___ 401(k)   ___ Pension   ___ Welfare Benefit

2. Total asset value of all plans combined for the most recent fiscal year: $ _____

This coverage part information section of the Application is deemed signed by an Executive Officer of the Applicant and dated as of the date set forth in section IV. of this Application.