TRAVELERS

Wrap+®

Designated Benefit Plan
Fiduciary Liability Coverage
Renewal Information Request

Travelers Casualty and Surety Company of America

The information requested in this Application is for a Claims-Made policy. If issued, the policy will apply only to claims first made during the policy period, or any applicable extended reporting period.

The limit of liability available to pay losses will be reduced and may be exhausted by the amounts paid as defense expenses. Defense expenses will be applied against the applicable retention or deductible. (For policies issued in New York, the limit of liability may be reduced up to 50% for amounts paid as defense expenses, and may be applied to up to 50% of the applicable deductible or retention.)

GENERAL INFORMATION

Name of Applicant:	Year Established:
Mailing Address:	
Renewal Effective Date (*mm/dd/yyyy*):	Type of Applicant: ☐ Multiemployer Plan ☐ Multiple Employer Plan ☐ Governmental Plan Number of government employees eligible to participate in plan _____ ☐ Other (explain) _____

Contact information of the Insurance Representative (the individual or entity designated by the Applicant to act as the Applicant's exclusive agent with respect to this insurance, including paying premiums and the giving or receiving of notices of cancelation, nonrenewal, or change of coverage):

Name of Insurance Representative:
Mailing Address:

Complete the table by providing information for the Applicant's existing insurance program:

Coverage	*Date First Purchased*	*Current Insurer*	*Expiration Date*	*Expiring Limit of Liability*	*Expiring Retention*	*Expiring Premium*
Fiduciary Liability				$	$	$

TRUST/PLAN INFORMATION

1. Will the Fiduciary Liability Coverage premium be paid by any trust or plan for which coverage is requested? ..... ☐ Yes ☐ No

2. Complete the chart for all trusts or plans for which coverage is requested:

Full Trust or Plan Name	**Type*	*Current Asset Value*	*Latest FYE Annual Contributions*	*Current # of Participants*	***Status*
		$	$		
		$	$		
		$	$		

If there are additional plans to be covered, attach details.

*Types: Defined Benefit (DB), Defined Contribution (DC, Welfare Benefit Plan (W), or Other (O) – attach explanation
**Status: Active (A), Frozen (F), or Terminated (T). If any trust or plan has been terminated, indicate date of transaction.

3. Please provide the names of firms providing the following services:

CPA	*Attorney*	*Actuary*	*Investment Adviser*

4. Has the Applicant changed outside auditors in the last 12 months?..... ☐ N/A ☐ Yes ☐ No

UNDERWRITING INFORMATION

5. Does any trust or plan not conform to the standards of eligibility, participation, vesting, blackout notification requirements, or other provisions of ERISA or any similar or related federal, state, local, or foreign law or regulation governing employee benefits? ..... ☐ Yes ☐ No
If yes, attach full explanation.

6. Has any trust or plan:
(a) been the subject of an investigation by the DOL, IRS, or any similar state agency;
(b) had its tax exempt status withdrawn or threatened to be withdrawn by the IRS;
(c) filed for an exemption from a prohibited transaction; or
(d) received an adverse opinion as to its financial condition by an independent public accountant?..... ☐ Yes ☐ No
If yes, attach full explanation.

7. If any trust or plan is a defined benefit trust or plan, has such trust or plan:
(a) experienced an event reportable to the PBGC;
(b) not been certified by an actuary to be adequately funded in accordance with the minimum funding standard of ERISA or any similar or related federal, state, local, or foreign law or regulation governing employee benefits; or
(c) been converted into a cash balance plan or is any such conversion expected in the next 12 months? If there are no defined benefit plans, please check "N/A"..... ☐ N/A ☐ Yes ☐ No
If yes, attach full explanation.

8. Has any trust or plan:
(a) been amended within the last 12 months in a way that will result in the reduction of benefits or are any such amendments anticipated within the next 12 months; or
(b) been merged with another trust or plan or terminated within the past 2 years, or is any such merger or termination anticipated in the next 12 months? ..... ☐ Yes ☐ No
If yes, attach full explanation.

9. Are there any outstanding or delinquent trust or plan contributions or trust or plan loans, leases, or debt obligations that are in default or classified as uncollectible?..... ☐ Yes ☐ No
If yes, attach full details.

LIMIT AND RETENTION INFORMATION

10. Do you desire any changes to the expiring policy limit or retention? ..... ☐ Yes ☐ No
If yes, indicate the desired changes below.

Coverage	*Limit of Liability*	*Retention*
Fiduciary Liability	$	$

11. If the requested limit of liability exceeds the limit of liability in the expiring Fiduciary Liability Coverage, answer the following question:
Solely with respect to any higher limits requested or that may ultimately be issued for the proposed insurance, is the Applicant or any person proposed for this insurance aware of any fact, circumstance, situation, event, or act that reasonably could give rise to a claim against them under the Fiduciary Liability Coverage for which the Applicant is applying? ..... ☐ Yes ☐ No
If yes, attach full details.

Solely with respect to any portion of the limit of liability for this proposed Fiduciary Liability Coverage that exceeds the amount of the expiring limit of liability for Fiduciary Liability Coverage in the expiring policy, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event, or act about which any natural person officer, including any executive director or functional equivalent thereof; member of the board of trustees; in-house risk manager, or in-house general counsel of the Applicant had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event, or act prior to the issuance of the proposed policy.

As part of this Application, provide copies of the documents listed below. The documents, as well as the representations and facts contained within such documents are made a part of this Application; the Insurer may elect to obtain requested information from public sources, including the Internet.

- Financial statements for all trusts or plans
- Most recent 5500 of all ERISA plans
- Schedule of trust and plan trustees
- Sponsor financial statement if Applicant is a multiple employer, government, or quasi-governmental plan

NOTICE REGARDING COMPENSATION

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Agency Compensation, One Tower Square, Hartford, CT 06183.

FRAUD WARNINGS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

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.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO, 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 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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, 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.

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

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

SIGNATURE AND AUTHORIZATION

The undersigned Authorized Representative of the Applicant declares that to the best of his or her knowledge and belief, after reasonable inquiry, the statements set forth in this application for insurance, including any supplements or materials made part of this application, are true and complete and may be relied upon by Travelers. If any information in this application, or any supplements or materials submitted therewith, changes prior to the inception date of the policy that Travelers may issue to the Applicant, the Applicant will notify Travelers of such changes and Travelers may modify or

withdraw any outstanding quotation. Travelers is authorized to make any investigation or inquiry in connection with this application.

The signing of this application does not bind Travelers to offer, nor the Applicant to purchase, the insurance. If the policy is issued, it is agreed that this application, including any supplements or materials made part of this application, will have been relied upon by Travelers in issuing the policy, will be the basis of the insurance, and will be, in all states other than NC and UT, considered physically attached to, and part of, the policy.

Authorized Representative Signature*: **X**	Authorized Representative Name - Printed	Date (mm/dd/yyyy):
Producer Signature* (required in FL and IA) **X**	State Producer License No (required in FL):	Date (mm/dd/yyyy):
Agency:	Agency Contact:	Agency Phone Number:

* If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance – Authorized Representative
☐ Electronic Signature and Acceptance – Producer