TRAVELERS

Wrap+®
Fiduciary Liability
Small Business Renewal Coverage Application

Travelers Casualty and Surety Company of America

IMPORTANT INSTRUCTIONS

This Application will only be accepted for *Privately held commercial companies* and *Non-Profit organizations* with:

- 250 or fewer employees; and
- $100 million or less in assets and $100 million or less in revenues

This Application will not be accepted for Public Companies, Unions, Churches, Government Entities or Financial Institutions

NOTICE

ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST INSUREDS DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED BY THE AMOUNTS INCURRED AS DEFENSE EXPENSES, AND DEFENSE EXPENSES WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY CLAIM UNLESS DUTY–TO-DEFEND COVERAGE IS SPECIFICALLY PROVIDED.

Applicant means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

I. APPLICANT INFORMATION

1. Name of **Applicant**: _____

   Street Address: _____ City: _____

   State: _____ ZIP Code: _____ Year **Applicant's** business was established: _____

2. Total number of full time and part time employees (including leased, seasonal and temporary): _____

3. For your most recent fiscal year end (_____/_____/_____) please complete the following financial information:

$_____	Current Assets	$_____	Revenues
$_____	Total Assets	$_____	Net Income (Net Loss)
$_____	Current Liabilities	$_____	Cash Flow from Operations
$_____	Long Term Debt	$_____	Net Equity/Net Assets (Deficit Equity)

4. Select Yes if either: (i) during the past 24 months the **Applicant** has experienced or (ii) during the next 12 months the **Applicant** anticipates:

   a. Any actual or proposed merger, acquisition, or divestiture? Yes ☐ No ☐

   b. A private placement of securities? Yes ☐ No ☐

   c. Any branch, location, facility, office, or subsidiary closings, consolidations, or layoffs? Yes ☐ No ☐

   d. Any violation of, or receipt of any amendment to, any debt covenant? Yes ☐ No ☐

   e. Any reorganization or arrangement with creditors under federal or state law? Yes ☐ No ☐

   If any of the questions 4. a.-e. above are answered Yes, please attach an explanation, including the timing, the essential terms of the event, the arrangement, the impact on employee base and the surrounding circumstances.

II. PLAN DATA

1. Premium to be paid by: Employer: ☐ Trust or Plan: ☐

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

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

***Plan Types:** Defined Contributions (DC) Defined Benefit (DB) ESOP (E) Welfare Benefit Plan (W) Other (O) – Attach Explanation

****Plan Status:** Active (A) Frozen (F) Sold (S) Terminated (T)

List any additional plans on a separate attachment.

3. During the past 24 months has (or during the next 12 months will) any plan for which coverage is requested:

   a. Been (Be) amended in a way that will result in the reduction of benefits? Yes ☐ No ☐

   b. Been (Be) merged with another plan, terminated or sold? Yes ☐ No ☐

   c. Been (Be) the subject of an investigation by the DOL, IRS, or any similar foreign agency? Yes ☐ No ☐

   d. Filed (File) for an exemption from a prohibited transaction? Yes ☐ No ☐

   e. Had (Have) any outstanding or delinquent contributions? Yes ☐ No ☐

   If any of the questions 3. a.-e. above are answered Yes, attach an explanation detailing the implementation, disclosure and any relevant blackout periods.

III. REQUESTED INSURANCE TERMS

1. Does the **Applicant** desire any changes to the expiring policy limit or retention? Yes ☐ No ☐
   If Yes, please indicate the desired changes in the table below:

(A) Expiring Limit	(B) Requested Limit	(C) Expiring Retention	(D) Requested Retention
$	$	$	$

Do not answer the next question unless the Requested Limit in Column (B) exceeds the Expiring Limit in Column (A).

2. Solely with respect to the higher limits requested or that may ultimately be issued for the proposed renewal, 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 Liability Coverage? Yes ☐ No ☐
   If Yes, please attach an explanation.

   *Solely with respect to any portion of the Limit for this Liability Coverage in the proposed policy that exceeds the amount of the Expiring Limit for this 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 executive officer 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.*

IV. REQUIRED ATTACHMENTS

As part of this Application, please submit the following documents (*these documents, and the representations and facts they contain, are made a part of this Application, whether such documents are physically delivered to the Company by the **Applicant** or are obtained by the Company from any public source, including the Internet*):

- Sponsor financial statement if **Applicant** maintains a defined benefit, self-funded welfare plan, an Employee Stock Ownership Plan (ESOP) or if the **Applicant** is a church, government or quasi-governmental entity

- Plan financial statements for defined benefit plans and self insured welfare plans, if limit requested is greater than $1,000,000
- Sponsor financial statement and plan financial statements for each defined contribution plan, if limit requested is greater than $5,000,000
- Employer Securities Supplemental Application, if any plan is an ESOP or if any other defined contribution plan invests in employer securities
- Most recent 5500's for all plans

V. COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

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, Enterprise Development, One Tower Square, Hartford, CT 06183.

VI. FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., 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.

Attention: Insureds in 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.

Attention: Insureds 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.

Attention: Insureds in 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.)

Attention: Insureds in 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.

Attention: Insureds in 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.

Attention: Insureds in 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.

VII. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PARTNER, PRINCIPAL, TRUSTEE OR OTHER OFFICER ACCEPTABLE TO TRAVELERS) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

REPRODUCED SIGNATURES, INCLUDING PHOTOCOPIES, WILL BE TREATED AS ORIGINAL.

Signature* of **Applicant's** Authorized Representative (Partner, Principal, Trustee or Officer)

Name (Printed)

Title

Date

***IF YOU ARE ELECTRONICALLY SUBMITTING THIS APPLICATION TO TRAVELERS, APPLY YOUR ELECTRONIC SIGNATURE TO THIS FORM BY CHECKING THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX BELOW. BY DOING SO, YOU HEREBY CONSENT AND 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.**

AUTHORIZED REPRESENTATIVE'S ELECTRONIC SIGNATURE AND ACCEPTANCE ☐

VIII. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE):

Producer Signature

Producer Name (Printed)

Agency Name

Agency Code

License Number