



**BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR COVERAGE WITH FEDERAL INSURANCE COMPANY OR VIGILANT INSURANCE COMPANY (THE "COMPANY")**

**NOTICE: THE FIDUCIARY LIABILITY COVERAGE SECTION OF THIS POLICY PROVIDES CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD," OR ANY EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY "DEFENSE COSTS," AND "DEFENSE COSTS" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COVERAGE AFFORDED UNDER THIS COVERAGE SECTION DIFFERS IN SOME RESPECTS FROM THAT AFFORDED UNDER OTHER POLICIES. READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.**

**APPLICATION INSTRUCTIONS:**

1. Whenever used in this Application, the term "**Applicant**" shall mean the Parent Organization and all organizations applying for coverage.
2. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.

**I. GENERAL INFORMATION:**

1. Name of **Applicant**: \_\_\_\_\_
2. Address of **Applicant**: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: \_\_\_\_\_
3. Web Address: \_\_\_\_\_ Stock Symbol (if applicable): \_\_\_\_\_
4. Name and Address of Primary Contact: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

**II. SPECIFIC INFORMATION:**

1. 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 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.

2. Limit of Liability Requested: \$ \_\_\_\_\_ Retention Requested: \$ \_\_\_\_\_

Does **Applicant** desire an optional proposal including Defense Costs outside the applicable Limit of Liability?  Yes  No  
 (Available on policies of \$5mm or less Limit of Liability.)



3. POLICY PERIOD REQUESTED

From: \_\_\_\_\_ to: \_\_\_\_\_ both days at 12:01 a.m. at the principal address of the Parent Organization.

4. Is any **Applicant** currently a general partner in any limited or general partnership?  Yes  No  
 If yes, attach details.

5. SUBSIDIARIES

Are there any new subsidiaries since inception of your current policy?  Yes  No  
 Attach a list of new subsidiaries to be covered including the following information:  
 nature of business, % owned, date acquired or created.

6. PLAN ADMINISTRATION

a. Does the **Applicant** delegate authority of the management and control of any plan's assets to any outside consultant(s)?  Yes  No

If yes, please explain and provide the following information with respect to each plan (attach supplemental schedule, if necessary):

<u>Type of Consultant</u>	<u>Name and Address</u>	<u>Years Employed</u>
Investment Advisor	_____	_____
Actuary	_____	_____
Legal Counsel	_____	_____
CPA	_____	_____
Administrator	_____	_____
Other(s)	_____	_____

b. Does the **Applicant** handle any investment decisions in-house?  Yes  No  
 If yes, describe. \_\_\_\_\_

c. Are plan benefits provided by insurance (e.g. annuity, medical policy, etc.)?  Yes  No  
 If yes, state the name of the insurance company. \_\_\_\_\_

7. PLAN INFORMATION (attach a schedule if necessary)

Plan Name	Type of Plan	Plan Assets Current Year	Plan Assets Prior Year	Total Current Plan Participants
<b>Total Assets</b>		\$	\$	



Types of Plan:

- Health and Welfare Plan = HWP
- Defined Contribution Plan = DCP
- Defined Benefit Plan = DBP
- Employee Stock Ownership Plan = ESOP\*
- Excess Benefit Plan or Top Hat Plan = EBP
- Other – Please explain: \_\_\_\_\_

\*If Applicant desires coverage for an ESOP plan, please complete the supplemental ESOP Application.

8. RECENT PLAN CHANGES

- a. Have there been any mergers of plans in the past 3 years?  Yes  No  
If yes, attach details.
- b. Has any plan or portion of any plan been sold, transferred or terminated in the past 3 years?  Yes  No  
If yes, attach 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.
- c. Is any plan a cash balance plan, or is any conversion to a cash balance plan being considered?  Yes  No  
If yes, attach complete details including copies of any descriptive literature distributed to plan participants and descriptions of any grandfather provisions.

9. COMPLIANCE

- a. Do the plans conform to the standards of eligibility, participation, vesting, funding and other provisions of ERISA?  Yes  No  
If no, please explain: \_\_\_\_\_
- b. Have the plans been reviewed to assure that there are no violations of prohibited transactions and party-in-interest rules?  Yes  No  
If no, please explain: \_\_\_\_\_
- c. Has any plan filed for an exemption from a prohibited transaction?  Yes  No  
If yes, attach filing and Department of Labor response.
- d. Has an actuary certified that the plans are adequately funded?  Yes  No  
If no, please explain: \_\_\_\_\_
- e. Are there any outstanding delinquent contributions?  Yes  No  
If yes, attach details.
- f. Have any plans experienced any event reportable to the PBGC?  Yes  No  
If yes, attach details.
- g. Within the last 3 years has any plan loaned money to, or invested in, the securities of the Applicant or its affiliates?  Yes  No  
If yes, please provide details including percentage of holdings.



10. PAST ACTIVITIES

- a. Has any fiduciary been:
  - i. accused, found guilty or held liable for a breach of trust?  Yes  No  
If yes, attach details.
  - ii. convicted of criminal conduct?  Yes  No  
If yes, attach details.
- b. Have any claims (other than for benefits) been made during the past 3 years against any benefit program or any current or past fiduciaries?  Yes  No  
If yes, attach details.
- c. 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?  Yes  No  
If yes, attach complete details.

11. PRIOR INSURANCE - **MISSOURI APPLICANTS/AGENTS: DO NOT ANSWER QUESTION a.**

- a. Has any current or past fiduciary liability insurance been refused, canceled or non-renewed?  Yes  No
- b. Has the **Applicant**, a subsidiary or any Insured Person, given written notice under the provisions of any prior or current fiduciary liability policy or specific facts or circumstances which might give rise to a claim being made against any Insured?  Yes  No  
If yes, attach details.
- c. Is there ERISA Fiduciary bond coverage currently in force?  Yes  No  
(If yes, indicate carrier.) \_\_\_\_\_
- d. Have any loss payments been made on behalf of any Insured under any fiduciary liability policy or similar insurance?  Yes  No  
If yes, attach details.
- e. Does the **Applicant** or any subsidiary currently have fiduciary liability insurance?  Yes  No  
If no, skip Section 12 and complete Section 13. If yes, please provide the following:

Insurer	Limits	Deductible	Policy Period
_____	\$ _____	\$ _____	_____

12. CONTINUITY WITH PRIOR COVERAGE

**Note:** This Section applies only if you currently have coverage and request continuity of coverage.

Continuity date requested: \_\_\_\_\_

If continuity of coverage is requested:

- a. attach a copy of the prior application with which continuity of coverage is to be maintained.



b. the Company will be relying upon the declarations and statements contained in such prior application and those declarations and statements shall be considered to be incorporated in and form a part of the policy of the Company.

13. REPRESENTATION: PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES/SITUATIONS

**Note:** This Section applies if you have requested continuity of coverage and your request has not been accepted or granted or if there is no prior coverage.

No person proposed for coverage is aware of any fact, circumstance, or situation which he or she has reason to suppose might give rise to any claim that would fall within the scope of the proposed coverage, except: NONE \_\_\_\_\_ or \_\_\_\_\_

Without prejudice to any other rights and remedies of the Company, the **Applicant** understands and agrees that if any such fact, circumstance, or situation exists, whether or not disclosed, in response to question 13 above, any claim or action arising from such fact, circumstance, or situation is excluded from coverage under any policy issued by the Company.

III. NOTICES:

The **Applicant's** submission of this Application does not obligate the Company to issue, or the **Applicant** to purchase, a policy. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Application.

**Notice to Arkansas, Minnesota and Ohio Applicants:** Any person who, with intent to defraud or knowing that he/she 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, which is a crime.

**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.

**Notice of District of Columbia, Maine, Tennessee and Virginia 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 Florida Applicants:** Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

**Notice to Kentucky Applicants:** Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.



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**Notice to Louisiana and New Mexico 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 civil fines and criminal penalties.

**Notice to Maryland Applicants:** Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**Notice to New Jersey Applicants:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Notice to New York Applicants:** 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**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 any insurance policy containing any false incomplete or misleading information is guilty of a felony.

**Notice to Oregon and Texas Applicants:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**Notice to Pennsylvania Applicants:** 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.

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#### **IV. MATERIAL CHANGE:**

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.

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#### **V. DECLARATION AND SIGNATURE:**

For the purposes of this Application, the undersigned authorized agent of the person(s) and entity(ies) proposed for this insurance declare to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and any attachments or information submitted with this Application, are true and complete. The undersigned agree that this Application and its attachments shall be the basis of a contract should a policy providing the requested coverage be issued and shall be deemed to be attached to and shall form a part of any such policy. The Company will have relied upon this Application, its attachments, and such other information submitted therewith in issuing any policy.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a Claim or potential Claim.



**Chubb Group of Insurance Companies**  
 15 Mountain View Road  
 Warren, New Jersey 07059

**Executive Protection Portfolio <sup>SM</sup>**  
**Fiduciary Liability Coverage**  
**Application**

This Application must be signed by an **Executive** who is a current fiduciary of a **Sponsored Plan** proposed for this insurance.

Date	Signature	Title
_____	_____	_____

Produced By:

Agent: \_\_\_\_\_ Agency: \_\_\_\_\_

Agency Taxpayer ID or SS No.: \_\_\_\_\_ Agent License No.: \_\_\_\_\_

Address (Street, City, State, Zip): \_\_\_\_\_

Submitted By:

Agency: \_\_\_\_\_

Taxpayer ID or SS No.: \_\_\_\_\_ Agent License No.: \_\_\_\_\_

Address (Street, City, State, Zip): \_\_\_\_\_