

Nonprofit Renewal Application



AmTrust North America
An AmTrust Financial Company

*To be able to save this form after the fields are filled in, you will need to have Adobe Reader 9 or later. If you do not have version 9 or later, please download the free tool at: <http://get.adobe.com/reader/>.

Renewal Application for:

Directors & Officers Liability

Employment Practices Liability

Fiduciary Liability

THE LIABILITY POLICY THAT MAY BE ISSUED BASED UPON THIS APPLICATION PROVIDES CLAIMS MADE COVERAGE WRITTEN ON A DUTY TO DEFEND BASIS. DEFENSE COSTS ARE OUTSIDE THE LIMIT UNLESS OTHERWISE SPECIFIED IN THIS POLICY. PLEASE READ THE POLICY AND APPLICABLE COVERAGE PARTS CAREFULLY.

Section I – General Information

Applicant (Organization): _____ FEIN #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

P.O. Box: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Date Organized: _____ Website: _____

Total annual revenue: \$ _____ Total fund balance (total assets minus total liabilities): \$ _____

Full-time employees: _____ Part-time employees: _____ Temporary/Seasonal: _____ Volunteers: _____

1. Is the Applicant or any of its subsidiaries involved in or presently considering any merger, consolidation, acquisition, divestment or sale of a portion of its business or has a similar transaction been considered or completed within the past three years? Yes No

If yes, please attach details.

2. In the past twelve (12) months, has there been a significant change in the Organization's:
a) legal structure? Yes No
b) tax exempt status? Yes No
c) nature of operations, including new programs? Yes No

If yes, please attach details.

Section II – Directors & Officers Liability Coverage

1. Has the Applicant experienced within the past year, or does it expect to experience in the next year, any changes in its Board of Directors or senior management? Yes No

If yes, please attach details.

Section III – Employment Practices Liability Coverage

Complete this section only if Employment Practices Liability coverage is desired.

1. Has the Applicant had any layoffs, staff reductions, downsizing or office closings in the past 12 months, or does the Organization anticipate any layoffs, staff reductions, downsizing, or office closings in the next 12 months? Yes No

If yes, please complete our Reduction in Force Supplement.

Section IV – Fiduciary Liability Coverage

Complete this section only if Fiduciary Liability coverage is desired.

1. Complete the following for all Plans:

Plan Name	Type of Plan* (see choices below)	Most Recent Asset Value	Year Established	Number of Participants
		\$		
		\$		
		\$		

* Plan Types: (a) Employee Welfare Benefit Plan; (b) Defined Contribution Plan (c) Defined Benefit (Pension) Plan; or (d) other

2. Is any Plan currently under examination or is any issue related to a Plan currently pending before the Internal Revenue Service, Department of Labor, the Pension Benefit Guaranty Corporation or any court?

Yes No

If yes, please attach details.

Section V – Claims History

1. Have there been during the last 5 years, or are there now pending, any inquiry, complaint, civil, criminal, administrative or arbitration proceedings (including any proceeding filed with the EEOC or state/local administrative agency) brought against any entity proposed for insurance, any person proposed for this insurance in their capacity as either director, officer, trustee, employee, volunteer, or staff member of any entity proposed for insurance or the employee benefit plans of any entity proposed for insurance?

Yes No

If yes, please complete our Claims Supplement for each claim.

Renewal Applicants: It is understood and agreed that if the undersigned or any insured has knowledge of any fact, circumstance or situation which could reasonably be expected to give rise to a future claim, then any increased limit of liability or coverage enhancement shall not apply to such fact, circumstance, or situation. In addition, any increased limit of liability or coverage enhancement shall not apply to any claim, fact, circumstance or situation for which the Insurer has already received notice.

Fraud Warning

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 may be a crime and may subject the person to criminal penalties.

ALABAMA, ARKANSAS, LOUISIANA, NEW JERSEY, NEW MEXICO, RHODE ISLAND, VIRGINIA and WEST VIRGINIA: 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. In Alabama, Arkansas, Louisiana, Rhode Island and West Virginia that person may be subject to fines, imprisonment or both. In New Mexico, that person may be subject to civil fines and criminal penalties. In Virginia, penalties may include imprisonment, fines and denial of insurance benefits.

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.

DISTRICT OF COLUMBIA, KENTUCKY 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 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. In District of Columbia, penalties include imprisonment and/or fines. In addition, the Insurer may deny insurance benefits if the Applicant provides false information materially related to a claim. In Pennsylvania, and subjects such person to criminal and civil penalties.

FLORIDA and OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive the Insurer, files a statement of claim or an Application containing any false, incomplete or misleading information is guilty of a felony. In Florida it is a felony to the third degree.

KANSAS: An act committed by 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 personal or commercial 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 is considered a crime.

MAINE: 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 denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against the Insurer, submits an Application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

TENNESSEE 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 may include imprisonment, fines and/or denial of insurance benefits.

Representation Statement

The undersigned declare that, to the best of their knowledge and belief, the statements in this Application, any prior Applications, any additional material submitted, and any publicly available information published or filed by or with a recognized source, agency or institution regarding business information for the Applicant for the 3 years prior to the Policy's inception [hereinafter called "Application"] are true, accurate and complete, and that reasonable efforts have been made to obtain sufficient information from each and every individual or entity proposed for this insurance. It is further agreed by the Applicant that the statements in this Application are their representations, they are material and that the Policy is issued in reliance upon the truth of such representations.

The signing of this Application does not bind the undersigned to purchase the insurance and accepting this Application does not bind the Insurer to complete the insurance or to issue any particular Policy. If a Policy is issued, it is understood and agreed that the Insurer relied upon this Application in issuing each such Policy and any Endorsements thereto. The undersigned further agrees that if the statements in this Application change before the effective date of any proposed Policy, which would render this Application inaccurate or incomplete, notice of such change will be reported in writing to the Insurer immediately.

Executive Director, President or Chairman of the Board:

Print Name: _____ Signature: _____

Title: _____ Date: _____

POLICY CANNOT BE ISSUED UNLESS THE APPLICATION IS SIGNED AND DATED BY AN AUTHORIZED REPRESENTATIVE

Agent Name: _____ License Number: _____

Agent Signature: _____

Submit Application to:

ustfnp@amtrustgroup.com

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