Proposal Form for Nonprofit Directors' and Officers' Liability, Employment Practices Liability, Fiduciary Liability, Coverages

ExecPro Nonprofit Solution

Name of Organization _____

Name of Management Company _____

Address _____ City _____

State_____ Zip Code_____ Organization's Website_____ Contact Person _____

Email _____ Phone _____ Fax _____

BACKGROUND INFORMATION

1. Describe the Organization's operations:

_____

2. a. Annual Salary/Wages Expense: $_____ b. Total Assets: $_____ c. Annual Revenue:$_____

   Provide the financial statements with this Proposal Form if the Organization and its Subsidiaries Total Assets are greater than $5,000,000, Annual Salary/Wages Expense is greater than $500,000, there is claims activity in the last 5 years, or if requested by the underwriter.

3. Please attach the following information on all Subsidiaries. If "None", please check this box: ☐ **None**
   (a) Name; (b) Date of acquisition/creation; (c) Percent of control; (d) Description of operations; (e) Operated for-profit or nonprofit; and (f) Name of parent organization. Attach financial statements (if not consolidated) for each subsidiary.

   COVERAGE IS NOT AUTOMATICALLY PROVIDED FOR ALL SUBSIDIARIES. TERMS AND CONDITIONS OF COVERAGE FOR SUBSIDIARIES ARE DETAILED IN SECTION III. D. OF THE POLICY.

4. Is the Organization 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 last three years?
   If "Yes", please attach details. ☐ Yes ☐ No

5. Does the Organization or any proposed Insured perform, or are they involved in, the following? *Check those that apply.*

   _____ Services involving Children
   _____ Collective Bargaining or Labor Advocacy
   _____ Mental Health / Rehabilitation Counseling
   _____ Medical Services
   _____ Legal or Arbitration Services
   _____ Teacher/Educator
   _____ Financial Counseling
   _____ Broadcasting / Publishing
   _____ Lobbying
   _____ Insurance or Investment Advisor
   _____ Foster Care / Adoption
   _____ Research & Development
   _____ Other Professional Services (Please provide full details)

6. Does the Organization take any disciplinary action or recommend disciplinary action as a result of credentials certification, accreditation, licensing, peer review or standard setting activities? ☐ Yes ☐ No

7. Provide: a. Date organized _____ b. Tax status: Taxable or Tax Exempt 501(c) _____

8. Is the Association or its Directors, Officers or employees involved in any of the following:

a. The performance of professional services on behalf of the Association? ☐ Yes ☐ No
b. The sponsorship, ownership, marketing or endorsement of any product, technology or service? ☐ Yes ☐ No
c. The certification or licensing of any current members? ☐ Yes ☐ No
d. The formation, development and or implementation of any guidelines/standards?
e. Arbitration, mediation or peer review (not including regular employee performance appraisal) activities, procedures or proceedings? ☐ Yes ☐ No
f. The publishing of any technical standards or procedural manuals? ☐ Yes ☐ No

If "YES" applies to any of the above, please provide full details and include sample materials with the application.

_____

_____

_____

PRIOR ACTIVITIES / KNOWLEDGE

1. Have there been during the last five years, or are there now pending, any civil, criminal, administrative or arbitration proceedings (including any proceeding initiated before the Equal Employment Opportunity Commission) brought against the Organization, its Subsidiaries, the Plans of the Organization or its Subsidiaries, or any person proposed for this insurance in their capacity as either Director, Officer, Trustee, employee, volunteer, or staff member of the Organization or its Subsidiaries? *If* "Yes", *for each proceeding please attach details of the complaint, the dollar amount of* costs *of defense and* loss, *the date the proceeding* was *filed, and whether the proceeding* is *open or closed.* ☐ **Yes** ☐ **No**

IT IS AGREED THAT ANY CLAIM ARISING FROM ANY PRIOR OR PENDING PROCEEDING IS EXCLUDED UNDER THE PROPOSED COVERAGE.

2. Is the undersigned or any proposed Insured aware of any fact, circumstance or situation involving the Organization or its Subsidiaries, the Plans of the Organization or its Subsidiaries, or any proposed Insured which he or she has reason to believe might result in a future Claim? If "Yes", *please attach details.* ☐ **Yes** ☐ **No**

IT IS UNDERSTOOD AND AGREED THAT IF KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION EXISTS, ANY CLAIM SUBSEQUENTLY ARISING THEREFROM SHALL BE EXCLUDED UNDER THE PROPOSED COVERAGE.

SUPPLEMENTAL QUESTIONS

1. Does the Organization currently have Directors' & Officers' and Employment Practices Liability Insurance?

ONLY APPLICABLE IF YOUR EXPIRING COVERAGE WAS WITH ANOTHER CARRIER

If "Yes", *please provide complete a-f:* ☐ **Yes** ☐ **No**

a. Carrier _____ b. Expiration Date _____ Retroactive Date _____

c. Limit _____ d. Premium _____ e. Retention _____

f. Has any carrier cancelled or non-renewed similar coverage? *If* "Yes", *please attach details.* ☐ **Yes** ☐ **No**
IN MISSOURI: Applicants should not respond to Question 1.f.

2. Provide the number of employees (including officers) at the Organization: _____

3. Provide the number of employees and officers who employment has been involuntarily terminated in the last twelve months and the number of employees and officers whose employment to be involuntarily terminated over the next twelve months through layoffs, facility closings, individual involuntary employee terminations or similar circumstances

Most recent twelve months: Number of employees and officers: _____
Next twelve months: Number of employees and officers: _____

If the turnover rate for the most *recent or next twelve months* is *greater than* 25%, *please attach additional details including the reason(s) for the involuntary terminations.*

4. In the last twelve months. have there been any changes in the Executive Director or President position for reasons other than death, retirement at the normal retirement age or term limitations? If "Yes", please attach additional details. ☐ **Yes** ☐ **No**

EMPLOYEE BENEFIT PLAN INFORMATION *(this section must be completed if a Fiduciary Liability option is requested. Provide Financial Statements for the Plans if Plan assets are greater than $25,000.000.)*

1. Please enter the Total Asset Value for each of the Employee Benefit Plans (referred to as the Plans) sponsored by the Organization or its Subsidiaries for which coverage is desired.

Plan	Total Asset Value
Defined Contribution Plans (including 401(k), 403(b), & 457 Plans)	_____
Defined Benefit Plans (including Traditional Pension Plans)	_____

2. Has the Organization or any Subsidiary terminated or contemplated terminating any of the Plans within the past three years or within the next 12 months? If "Yes", *please attach details.* ☐ Yes ☐ No

3. Do any of the Plans fail to comply with the "Employee Retirement Income Security Act of 1974" (ERISA) where applicable? If "Yes", *please attach details.* ☐ Yes ☐ No

4. Has any Plan had, at any time during the last three years, a funding deficiency? If "Yes", *please attach details.* ☐ Yes ☐ No

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Attention- Applicants in AR, CO, DC, KY, NJ, NM, NY, OH, OK, PA, TN, VA:
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 may also be subject to a civil penalty.

In Colorado: *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.*

In Florida: *Any person who knowing 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.*

Also provide: *Agent Name:* _____ *Agent License#:* _____

In Iowa and New Hampshire:

Provide: *Producer Signature* _____ *Date:* _____

In New York: *Any person who knowingly. and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information. or conceals for the purpose of misleading 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 ($5,000.00) and the stated value for each such violation.*

In Washington, Maine and Louisiana: *It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company (including false information in an application for insurance and claim for payment of loss or benefit). Penalties include imprisonment. fines and denial of insurance benefits.*

It is agreed the particulars and statements contained in Proposal Forms submitted to the Insurer (and any material submitted therewith) are the representations of the Insured and are to be considered as incorporated in and constituting part of this Policy. It is also agreed this Policy is issued in reliance upon the truth of such representations. However, coverage shall not be excluded as a result of any untrue statement in the Proposal Form, except:

(1) as to any Insured Person making such untrue statement or having knowledge of its falsity; or

(2) as to the Organization and any Subsidiary, if the person(s) who signed the Proposal Form(s) for this coverage or any Insured Person who is or was a past, present or future Chief Financial Officer, President, or Executive Director of the Organization made such untrue statement or had knowledge of its falsity.

By _____ _____ _____

SIGNATURE OF EXECUTIVE DIRECTOR *PRINT NAME* *DATE*

The above individual is also designated as agent of the Organization and all of the Insureds to receive any and all notices from the Insurer.

This Proposal Form, including any material submitted therewith, shall be treated in strictest confidence. Submit this Proposal Form including documentation to:

AMBA
4050 114th Street
Des Moines, IA 50322

Email: luz.maysonet@getamba.com

Fax: 515-993-9681