Please submit this form to:
XS/Group, Inc.
Deborah H. Custis
dcustis@xsgroup.net
2750 Killarney Drive, #202
Woodbridge, VA 22192-4124

AP Reset

Proposal Form
(New York only)

Fiduciary Liability Insurance

CLAIMS MADE WARNING FOR APPLICATION

THIS PROPOSAL FORM IS FOR A CLAIMS MADE POLICY, RELATING TO CLAIMS MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the **Policy**. This Proposal Form is to be completed with respect to the entire **Insured Entity**. **Insured Entity** as used herein is defined to include the **Named Insured** and any **Subsidiaries**.

Name of **Named Insured**

Street Address | Suite

City | County | State | Zip Code

Website Address (if applicable) | Federal Employer Identification Number (FEIN)

The Officer designated as agent of the **Insured Entity** and of all **Insureds** to receive any and all notices from the **Insurer** or their authorized representatives concerning this insurance:

Contact Name | Title

E-mail Address | Telephone Number | Fax Number

Producer Information

Submitted by (Agency Name) | Dated

Agent's Name (Individual's Name) | Agent's License Number

Limit Requested

Fiduciary Liability Insurance:
Indicate the type of limit requested:

Limit Requested: $

❑ Combined Aggregate Limit of Liability

❑ Separate Aggregate Limit of Liability

Current Insurance Information (Provide details to all "Yes" answers by attachment)

1. Provide the following information regarding the **Insured Entity's** most recent insurance policies. If "None", so state.

Type of Policy		Insurance Carrier	Expiration Date	Limit of Liability	Deductible	Premium
Directors and Officers Liability:	❑ None			$	$	$
Employment Practices Liability:	❑ None			$	$	$
Fiduciary Liability:	❑ None			$	$	$
General Liability:	❑ None			$	$	$
Other:_____	❑ None			$	$	$

2. Has the Extended Reporting Period (or Discovery Period) been exercised for the **Insured Entity's** most recent Directors and Officers Liability, Employment Practices Liability, or Fiduciary Liability insurance policies? ❑ Yes ❑ No

3. Within the last 3 years, has any **Claim** been made or has notice been given under any of the previous policies for Directors and Officers Liability, Employment Practices Liability or Fiduciary Liability insurance or similar insurance? ❑ Yes ❑ No

4. Within the last 3 years, has any Directors and Officers Liability, Employment Practices Liability, Fiduciary Liability insurance, or similar insurance policies for the **Insured Entity** ever been cancelled or non-renewed? NOT APPLICABLE IN MISSOURI ❑ Yes ❑ No

Documents Required (The following information must be submitted with the completed Proposal Form).

- Provide details to all "Yes" answers, when applicable, by attachment
- A copy of the most recent public accountant's audit report or IRS Form 5500 for each **Employee Benefit Plan**

Carolina Casualty Insurance Company

Fiduciary Liability Insurance Information

1. Provide the following information regarding each employee welfare benefit plan, employee pension benefit plan or pension plan, as defined by **ERISA**, (hereinafter referred to as **Employee Benefit Plan(s)**) which the **Insured Entity** maintains or to which it contributes.

Name of Plan	Type of Plan*	Name of Plan Sponsor	Number of Plan Participants	Fair Market Value of Plan Assets

*Type of Plan: (DB)=Defined Benefit; (DC)=Defined Contribution; (ESOP)=Employee Stock Ownership Plan; (WB)=Health & Welfare Benefit; (MEP)=Multi Employer Plan or Multiple Employer Plan; (O)=Other

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR EMPLOYEE BENEFIT PLAN(S) IN QUESTION 1. FOR WHICH THE ABOVE INFORMATION IS INCOMPLETE OR NOT PROVIDED.

2. Has any employee pension benefit plan or pension plan invested in securities of the **Insured Entity**? If "Yes", provide the following details by attachment: number of shares; cost of shares to the plan; fair market value of shares. ❑ Yes ❑ No
3. Has any employee pension benefit plan or pension plan invested in more than 10 percent of any entity (other than the **Insured Entity** or a pooled investment vehicle such as a mutual fund)? If "Yes", provide name of entity and amount of investment by attachment. ❑ Yes ❑ No
4. Has any **Employee Benefit Plan** loaned or pledged any **Employee Benefit Plan** assets to any party-in-interest (including the **Insured Entity**)? If "Yes", provide details by attachment. ❑ Yes ❑ No
5. Are any defined benefit plans under funded by more than 20 percent? If "Yes", provide details by attachment. ❑ Yes ❑ No
6. Are there any overdue employer contributions for any plan, or has any plan requested or contemplated filing a request for a waiver of contributions? If "Yes", provide plan name and amount of overdue contributions by attachment. ❑ Yes ❑ No
7. Within the last 3 years, has there been, or is there currently under consideration, any restructuring, spin-off, transfer, consolidation, merger, termination or other similar transaction of any **Employee Benefit Plan**? ❑ Yes ❑ No
   If "Yes", provide the following details of the transaction by attachment: whether assets have been fully distributed; date or expected date of any transfer of employees or **Employee Benefit Plans**; copies of any materials relating to the transaction that were distributed to employees or filed with government agencies.
8. If any of the following questions are answered "No", provide details by attachment.
   (a) Are all **Employee Benefit Plans** compliant with the Health Insurance Portability and Accountability Act ("HIPAA")? ❑ Yes ❑ No
   (b) Does the plan sponsor comply with the summary plan description requirements under **ERISA** for all **Employee Benefit Plans**? ❑ Yes ❑ No
   (c) Do all employee pension benefit plans or pension plans have a written investment policy? ❑ Yes ❑ No
   (d) Are all employee pension benefit plan or pension plan assets managed by a third party investment manager? ❑ Yes ❑ No
   (e) Do the fiduciaries review the investment guidelines used by the investment managers at least annually? ❑ Yes ❑ No
   (f) Is the "fair market value" of all employee pension benefit plan or pension plan assets calculated at least annually? ❑ Yes ❑ No
9. During the last 5 years, has there been, or is there currently, any investigation by the IRS, Department of Labor ("DOL"), Pension Benefit Guarantee Corporation ("PBGC"), or any other state or federal agency of any **Employee Benefit Plan** or any current or former fiduciary of such **Employee Benefit Plan**? If "Yes", provide details by attachment. ❑ Yes ❑ No
10. During the last 5 years, has any **Insured** been named as a party in any civil or criminal action, administrative, arbitration, regulatory or investigative proceeding, or received any other written demands for money or services that would be within the scope of this proposed insurance? ❑ Yes ❑ No
11. Is any **Insured** aware of any fact, circumstance or situation involving any **Insureds** that might reasonably be expected to result in a **Claim**? ❑ Yes ❑ No

IF "YES" TO QUESTIONS 10. OR 11., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

(a) Date **Claim** first made (b) Claimant's Name (c) Allegation (d) Current Status
(e) Demand Amount (f) Settlement (Indemnity) or Reserve Amount (g) Attorney's fees

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTIONS 10. OR 11.

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 TO NEW MEXICO, 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.

NOTICE TO APPLICANTS OF KENTUCKY: 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, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO APPLICANTS OF MINNESOTA, NEW JERSEY, OHIO, AND OKLAHOMA: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO MAINE, MASSACHUSETTS, TENNESSEE, VIRGINIA, AND WASHINGTON 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO APPLICANTS OF 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.

NOTICE TO ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MARYLAND, AND RHODE ISLAND 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 FINES AND CONFINEMENT IN PRISON.

Please Read Carefully

The undersigned, acting on behalf of all **Insureds**, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each and every **Insured** proposed for this insurance to facilitate the proper and accurate completion of this Proposal Form.

The undersigned agree that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and are the basis of the insurance contract. The undersigned further agree that the Proposal Form and any material submitted herewith shall be considered attached to and a part of the **Policy**. Any material submitted with the Proposal Form shall be maintained on file (either electronically or paper) with the **Insurer** and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the **Policy** inception date, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any **Policy**, if issued, will be in reliance upon the truth of such representations; provided, however, with respect to such statements and representations, no knowledge or information possessed by any **Insureds** shall be imputed to any other **Insureds**. If any person or persons knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons. However, if the Chairperson of the Board of Directors, President, Chief Executive Officer, or Chief Financial Officer of the **Insured Entity** knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons and the **Insured Entity**;
- this Proposal Form has been completed as respects the entire **Insured Entity**;
- the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

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.

Dated	President, Chief Executive Officer, Chief Financial Officer, or equivalent position (Signature)
Title	President, Chief Executive Officer, Chief Financial Officer, or equivalent position (Print Name)

This Carolina Casualty Insurance Company Proposal Form, including any material submitted herewith, shall be held in strictest confidence.

A POLICY CANNOT BE ISSUED UNLESS THE PROPOSAL FORM IS PROPERLY SIGNED AND DATED.

Please submit this Proposal Form including appropriate documentation to:

Monitor Liability Managers, LLC, 2850 West Golf Road, Suite 800, Rolling Meadows, IL 60008-4039