TRAVELERS

Wrap+®

Non-Profit Organization Directors and Officers Liability and Employment Practices Liability Small Organization Coverages Application

Travelers Casualty and Surety Company of America

IMPORTANT INSTRUCTIONS

This Application will only be accepted for *Non Profit Organizations* with:

- 30 or fewer employees; and
- $5 million or less in assets and $5 million or less in revenues

This Application will not be accepted for any For Profit 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, UNLESS OTHERWISE SPECIFICALLY PROVIDED BY ENDORSEMENT TO THE LIABILITY COVERAGE. 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: _____

   Description of Operations: _____

2. Scope of Operations (check one):

   ☐ International or National ☐ Regional (operates in more than one state) ☐ Statewide ☐ Local

3. Does the **Applicant** now have tax exempt status under the United States Internal Revenue Code? Yes ☐ No ☐

4. Is there now, or has there been, any dispute as to the **Applicant's** tax exempt status? Yes ☐ No ☐
   If Yes, please attach an explanation.

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

6. Total number of locations: _____

*Note: Omit question 7. below and attach the most recent annual financial statement if the limit requested is $3,000,000 or greater, or if the **Applicant** receives any Government funding.*

7. 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)

8. Does the **Applicant** have any subsidiaries or control any other entity or organization for which coverage is requested? Yes ☐ No ☐
   If Yes, please attach a description of operations, ownership, and tax status for each such entity.

9. 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. Any branch, location, facility, office, or subsidiary closings, consolidations, or layoffs? Yes ☐ No ☐
   c. Any violation of, or receipt of any amendment to, any debt covenant? Yes ☐ No ☐
   d. Any reorganization or arrangement with creditors under federal or state law? Yes ☐ No ☐

   If any of the questions 9. a.-d. 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.

10. Does the **Applicant** or any subsidiary perform any professional services, which may include but are not limited to, accrediting, credentialing, standard setting or licensing for others? Yes ☐ No ☐
    If Yes, please attach an explanation.

11. Does the **Applicant** engage in publishing, other than a newsletter? Yes ☐ No ☐
    If Yes, please attach an explanation.

12. Is the **Applicant** managed or administered by any third party under contract or agreement? Yes ☐ No ☐
    If Yes, please attach an explanation.

13. Does the **Applicant** currently carry General Liability Insurance? Yes ☐ No ☐

14. If applicable, indicate the following: Number of Members:_____ Number of Chapters:_____ N/A ☐

II. EMPLOYEE AND HUMAN RESOURCES INFORMATION

1. Indicate the total number of*:*

	As of Application Date	***Previous 12 Months***
Full Time Employees*	_____	_____
Part Time Employees*	_____	_____

** Include leased, seasonal, and temporary employees.*

2. Total number of union employees included above: _____

3. Total number of employees compensated: (a) less than $50,000 annually? _____
   (b) greater than $100,000 annually? _____

4. Number of employees involuntarily terminated** (a) in the current year:_____ (b) in the prior year:_____
   ** *Do not include terminations due to layoffs.*

5. Is Human Resource personnel or employment counsel consulted prior to terminations? Yes ☐ No ☐

6. Does the **Applicant** have written guidelines, policies or procedures related to the following:

   a. Employment at Will? Yes ☐ No ☐
   b. Discrimination? Yes ☐ No ☐
   c. Sexual and Other Workplace Harassment? Yes ☐ No ☐
   d. Equal Employment Opportunity? Yes ☐ No ☐
   e. Disabled Employees and Reasonable Accommodations? Yes ☐ No ☐
   f. Reporting, Investigating and Resolving Employee Complaints? Yes ☐ No ☐

7. Are employees required to acknowledge receipt of the above guidelines, policies and procedures? Yes ☐ No ☐

8. Has employment counsel reviewed the above guidelines, policies, and procedures? Yes ☐ No ☐

9. Does the **Applicant**:

   a. Utilize employment applications? Yes ☐ No ☐
   b. Document employee performance? Yes ☐ No ☐
   c. Conduct human resources training for management employees? Yes ☐ No ☐

III. CURRENT INSURANCE INFORMATION/REQUESTED INSURANCE TERMS

Liability Coverage	(A) Requested Limit	(B) Coverage Currently Purchased	(C) Expiring Limit	(D) Expiring Retention
Non-Profit Organization Directors and Officers	$	Yes ☐ No ☐	$	$
Employment Practices	$	Yes ☐ No ☐	$	$

Expiring insurer: _____ Expiring premium: $_____
Date coverage first purchased: _____ Requested effective date: _____

1. If Liability Coverage is currently purchased as indicated in Column (B) above, but has been in place for less than 3 years, please answer the following question:

   As of the date the **Applicant** first purchased the Liability Coverage, 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 being made against them under the Liability Coverage for which the **Applicant** is applying? Yes ☐ No ☐
   If Yes, please attach an explanation.

2. If Liability Coverage is not currently purchased as indicated in Column (B) above, please answer the following question:

   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 for which the **Applicant** is applying? Yes ☐ No ☐
   If Yes, please attach an explanation.

3. If the Requested Limit in Column (A) exceeds the Expiring Limit in Column (C), please answer the following question:

   Solely with respect to any higher limits requested or that may ultimately be issued for the proposed insurance, 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 for which the **Applicant** is applying? Yes ☐ No ☐
   If Yes, please attach an explanation.

*With respect to the information required to be disclosed in response to the questions above, 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. LOSS INFORMATION

Has any person or entity proposed for this insurance been a party to any claim which would have fallen within the scope of this coverage including but not limited to criminal actions, administrative or regulatory proceedings, charges, hearings, demands, lawsuits, or employment-related claims during the past 3 years, whether or not insured? Yes ☐ No ☐
If Yes, please attach a full explanation, including date, description, defense expenses and damages paid, status, whether there was insurance and any procedures implemented to avoid further claims.

V. 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*) if **Applicant**:

- Receives Government funding or limit requested is $3,000,000 or greater, most recent annual audited financial statement
- Is a *start-up*, a copy of organization plan and list of outside affiliations of Directors and Officers
- Is a *country club*, a copy of club rules, constitution, and by-laws
- Is an *agricultural cooperative*, complete the Agricultural Cooperative Supplemental Application
- Is a *school*, complete the School Supplemental Application

- Has locations in more than one state or foreign country, attach a list including employee counts, of the ***5 states or foreign countries*** with the greatest number of **Applicant** employees

VI. 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.

VII. 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.

VIII. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PRESIDENT, CEO, EXECUTIVE DIRECTOR 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 (President, CEO, Executive Director)	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 ☐

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

Producer Signature	Producer Name (Printed)	
Agency Name	Agency Code	License Number