Carolina Casualty Insurance Company

Proposal Form

4600 Touchton Road East, Building 100, Suite 400, Jacksonville, FL 32246

Nonprofit Management Liability Insurance

CLAIMS MADE WARNING FOR APPLICATION

THIS PROPOSAL FORM IS FOR A CLAIMS MADE AND REPORTED POLICY, RELATING TO CLAIMS MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR THE 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

Coverage Section(s) Requested

Directors, Officers and Organization Liability Insurance **Coverage Section**: ❑ Yes ❑ No Limit Requested: $

Employment Practices Liability Insurance **Coverage Section**: ❑ Yes ❑ No Limit Requested: $

Fiduciary Liability Insurance **Coverage Section**: ❑ Yes ❑ No Limit Requested: $

Indicate the type of limit requested:
❑ Combined Aggregate Limit of Liability for all **Coverage Sections**, or
❑ Separate Aggregate Limit of Liability for each **Coverage Section**

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			$	$	$

2. 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
3. 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

General Information (Provide details to all "Yes" answers by attachment, when appropriate)

4. (a) Does the **Insured Entity** currently have a tax-exempt status under the U.S. Internal Revenue Service Code? ❑ Yes ❑ No
   If "Yes", under which IRSC Section? ______
   If "No", provide an explanation by attachment.
   (b) Have there been or are there now pending, any disputes as to the **Insured Entity's** tax-exempt status? ❑ Yes ❑ No
5. The **Named Insured** has been in continuous operation since: ______
6. Describe the **Insured Entity's** nature of operations: ______
7. Does the **Insured Entity** own or hold any patents? If "Yes", how many? ______ ❑ Yes ❑ No

8. Does the **Insured Entity**:
   (a) provide any professional services including, but not limited to, legal counseling, medical care, peer review and credentialing activities to others? ❑ Yes ❑ No
   (b) promote, sponsor or provide any form of insurance to its members or non-members? ❑ Yes ❑ No
   (c) transact electronic commerce on behalf of itself, members or third parties? ❑ Yes ❑ No
   (d) have a membership in any nonprofit or professional associations? If "Yes", provide association name(s) below. ❑ Yes ❑ No

   ______________________________ ______________________________

9. Provide the following information on all **Subsidiaries** or related organizations of the **Insured Entity**. If "None", so state. ❑ None

Subsidiary or Organization Name	Nature of Business	Not For Profit?	Total Assets	Is coverage requested for this entity under this Policy?
		❑ Yes, IRSC:________ ❑ No	$	❑ Yes ❑ No
		❑ Yes, IRSC:________ ❑ No	$	❑ Yes ❑ No

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES OR RELATED ORGANIZATIONS IN QUESTION 9. UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED.

10. Provide the following financial information with respect to the **Insured Entity**: Period Ending: ____/____/____
    Assets (000): $__________ Fund Balance (000): $__________ Annual Revenues (000): $__________

11. (a) Is the **Insured Entity** currently in bankruptcy? ❑ Yes ❑ No
    (b) Within the next 12 months, is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code? ❑ Yes ❑ No

12. Within the last 3 years, have there been resignations, departures, retirements, or terminations in the position of the Chairperson of the Board of Directors, President, Chief Executive Officer, Executive Director, or Chief Financial Officer? ❑ Yes ❑ No
    If "Yes", provide the following details by attachment: Name of individual; date of change; and reason for change.

13. Number of **Employees**:

	Full Time	Part Time	Leased	Seasonal and/or Temporary	Volunteers and/or Interns	Independent Contractors	Annual Turnover Rate
Current Year:							
Last Year:							

14. What percentage of the **Insured Entity's Employees** currently earns more than $100,000? ________%

15. Does the **Insured Entity** currently employ a full time Human Resources professional? ❑ Yes ❑ No

16. Indicate which formal written policies and procedures have been implemented. If "None", so state. ❑ None
    ❑ Employee Handbook / Manual
    ❑ Anti-Discrimination Policy – Equal Employment Opportunity (EEO) Policy
    ❑ Anti-Harassment Policy, including Sexual Harassment
    ❑ Adherence to Employment "at-will" relationship with all **Employees**
    Employers with more than 50 Employees
    ❑ Family Medical Leave Act
    California Employers Only
    ❑ California Family Rights Act

Litigation and Claim Information

17. During the last 5 years, has the **Insured Entity** or any of the **Insured Persons** received any written demands for monetary or non-monetary relief, been involved in, or had any knowledge of any civil or criminal action, administrative or arbitration proceeding, including both domestic or foreign equivalents, involving:
    (a) any intellectual property disputes, including Copyright, Patent, or Trademark Laws? ❑ Yes ❑ No
    (b) any alleged violation of any Federal or State Security Law or Regulation? ❑ Yes ❑ No
    (c) any alleged violation of any Federal or State Anti-Trust or Fair Trade Law? ❑ Yes ❑ No
    (d) any other allegations of violations of federal, state or local statute, regulation, ordinance or common law that would otherwise be within the scope of this proposed insurance? ❑ Yes ❑ No

18. During the last 5 years, has any **Insured** known of, or been involved in any lawsuit, charges, inquiries, investigations, grievances or other administrative hearings or proceedings before any of the following agencies and/or in any of the following forums, including both domestic or foreign equivalents?
    (a) National Labor Relations Board? ❑ Yes ❑ No
    (b) Equal Employment Opportunity Commission? ❑ Yes ❑ No
    (c) Office of Federal Contract Compliance Programs? ❑ Yes ❑ No
    (d) U.S. Department of Labor? ❑ Yes ❑ No
    (e) Any state or local government agency such as the Labor Department or fair employment agency? ❑ Yes ❑ No
    (f) U.S. District or state court? ❑ Yes ❑ No

19. During the last 5 years, has any current or former **Employee** or third party made any **Claim**, or otherwise alleged discrimination, harassment, wrongful discharge and/or **Wrongful Acts** against any **Insured**? ❑ Yes ❑ No
    A **Claim** is not limited to the filing of a lawsuit or complaint with the Equal Employment Opportunity Commission or similar state or local agency. A **Claim** may also include a written demand by any current or former **Employee** seeking relief in connection with an employment-related dispute or grievance.

20. Is any **Insured** aware of any fact, circumstance or situation involving any **Insureds** that might reasonably be expected to result in a **Claim** as defined in each **Coverage Section** applied for? ❑ Yes ❑ No

IF "YES" TO ANY PART OF QUESTIONS 17., 18., 19., OR 20., 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 17., 18., 19., OR 20.

Provide Additional Information here

<u>NOTICE TO COLORADO APPLICANTS:</u> 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.

<u>NOTICE TO NEW YORK APPLICANTS:</u> 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.

<u>NOTICE TO NEW MEXICO, PENNSYLVANIA APPLICANTS:</u> 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.

<u>NOTICE TO APPLICANTS OF KENTUCKY:</u> 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.

<u>NOTICE TO APPLICANTS OF MINNESOTA, NEW JERSEY, OHIO, AND OKLAHOMA:</u> 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.

<u>NOTICE TO DISTRICT OF COLUMBIA, MAINE, MASSACHUSETTS, TENNESSEE, VIRGINIA, AND WASHINGTON APPLICANTS:</u> 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.

<u>NOTICE TO APPLICANTS OF FLORIDA:</u> 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.

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 that they are material 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 Executive Director 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 <u>entire</u> **Insured Entity**;
- and the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

______________________	____
Dated	Chairperson of the Board of Directors, President, Chief Executive Officer or Executive Director (Signature)
______________________	____
Title	Chairperson of the Board of Directors, President, Chief Executive Officer or Executive Director (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, Inc., 2850 West Golf Road, Suite 800, Rolling Meadows, IL 60008-4039