



P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

FIDUCIARY LIABILITY APPLICATION

GENERAL INFORMATION

1. Legal name of the business which is the primary applicant and will be the first named insured listed on the policy: _____
 2. Please list all other business/dba names, including subsidiaries for which you are seeking coverage under this policy: _____
 3. Applicant is: Individual Partnership Corporation
 Non-Profit Privately Held Publicly Traded
 4. Please list any names of other entities that you own or manage or that you do business under (such entities are not requesting coverage under this policy): _____
 5. Subsidiaries – Please attach the following information on all subsidiaries (including subsidiaries of subsidiaries):
 - a. Name and address
 - b. Percentage of ownership
 - c. Nature of business
 - d. Name of Parent Company
 6. Primary location address: _____
 7. County of primary location: _____ Date business originally established: _____
 8. Total number of branches: _____ List all addresses for additional branches: _____
 9. What is your web-site address? www. _____
 10. What is your phone number? _____
 11. Has the name or ownership of the entity changed or has any other business been purchased, merged or consolidated with the entity within the last 5 years? Yes No
 12. Does any entity own or control your business or does your business own or control any entity? Yes No
 13. During the past five years, has your name been changed or has any other business purchased, merged or consolidated with you? Yes No
- For questions 9-11, please fully explain any “yes” response, including the names, dates, and revenue impact involved:

14. Please list any associations of which you are a member: _____
 15. Please describe the nature of the Applicant’s business (type of product or services provided). _____

ORGANIZATION INFORMATION

1. In the next 12 months (or during the past 24 months) is the Applicant contemplating (or has the Applicant completed or been in the process of completing) the following:
 - a. Any actual or proposed merger, acquisition, or divestiture? Yes No
 - b. Any creation of a new organization, subsidiary, or division? Yes No
 - c. Any reorganization or arrangement with creditors under federal or state law? Yes No
 - d. Any branch, location, facility, office, or subsidiary closings, consolidations, or layoffs? Yes No

If any of the questions above were answered Yes, please attach an explanation, including the timing, the essential terms of the event, arrangement, impact on employee base and the surrounding circumstances.

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

3. Does the Applicant manage or administer any entity (other than the Applicant Entity) under contract or agreement? *If Yes, please attach an explanation.* Yes No

REQUESTED COVERAGE

- Total assets of all plans to be covered: \$ _____
- Total number of employees covered by all plans: _____
- List the names of all employee benefit plans for which coverage is requested. (Complete a separate plan questionnaire for each plan listed below.)

FINANCIAL INFORMATION

1. Complete the following chart providing the requested financial information:

Indicate the following as it relates to the Applicant's fiscal year end (FYE): <i>(Please indicate negative figures with "(")" or "-" as appropriate)</i>	Most Recent FYE (Month/Year) (____ / ____)	Prior FYE (Month/Year) (____ / ____)
Total Assets	\$ _____	\$ _____
Long Term Debt	\$ _____	\$ _____
Net Equity/Net Assets (Deficit Equity)	\$ _____	\$ _____
Revenues	\$ _____	\$ _____
Net Income (Net Loss)	\$ _____	\$ _____

2. Is the Applicant currently (or has it been in the past 24 months) in violation of, or has it received an amendment to any debt covenant? Yes No
If Yes, please attach an explanation.

EMPLOYEES (including Subsidiary employee information on a separate sheet)

- Number of Employees: Full Time: _____ Part Time: _____
- Number of Volunteers: _____ How many hours per week do volunteers work on average? _____
 Number of Independent Contractors: _____ How many work solely for the Applicant? _____
- Please describe the services performed by Volunteers for or on behalf of your Organization. _____

- Please describe the services performed by Independent Contractors: _____

5. Salary Ranges <i>(including bonuses, dividends and commissions)</i>	Number of full time employees	Number of part time employees
\$50,000 or less:	_____	_____
\$50,001 to \$100,000:	_____	_____
\$100,001 and over:	_____	_____
TOTAL:	_____	_____

If you have multiple locations, please list the number of employees by state:

	State:	State:	State:	State:	State:
Full-Time					
Part-Time					
Volunteers					
Independent Contractors					

6. Does the Applicant use seasonal or temporary employees? Yes No
 If so, when and how many? _____
 Are these employees included in #4 above? Yes No
7. Does the Applicant use leased workers? Yes No
 If Yes, how many have been retained by the Applicant in the past 12 months? _____
 Are these employees included in #5 above? Yes No
8. How many employees are covered by collective bargaining or other union agreements? _____
9. In the past 12 months, how many officers have left your employ? _____
 Of the above, how many were terminated? _____
10. In the past 12 months, how many other employees have left your employ? _____
 Of the above, how many were terminated? _____
11. In the past twelve (12) months, has your total number of employees decreased by more than ten percent (10) or five (5) employees, whichever is **greater**, through any reduction in force, systematic lay-off, closure of any division, office or facility that you own or operate or for any other reason? *(If Yes, please complete the Reduction In Force supplement.)* Yes No
12. In the next twelve (12) months, do you anticipate the total number of your employees to decrease by more than ten percent (10%) or five (5) employees, whichever is **greater**, through any reduction in force, systematic lay-off, closure of any division, office or facility that you own or operate or for any other reason? *(If Yes, please complete the Reduction In Force supplement.)* Yes No
13. If during the next 12 months, circumstances of which you are currently unaware make it necessary for you to decrease the number of your employees by ten percent (10%) or five (5) employees, whichever is greater, through the implementation of any reduction in force, systematic layoff, closure of any division, office or facility that you own or operate or for any other reason (with any such reduction, lay-off or closure not known, anticipated or planned by you as of the date of this Application), do you agree that you will consult with, and adopt the advice of, a lawyer who specializes in labor and employment law (may include in-house counsel, but only if that counsel is qualified and experienced in the practice of labor and employment law) as respects the implementation of such reduction, lay-off or closure? *(If No, please explain on a separate sheet.)* Yes No

	Insurance Company	Limits Per Claim/ Aggregate	Deductible	Policy Period (Month/Day/Year)	Retro Date	Annual Premium
Previous Year 1						
Previous Year 2						
Previous Year 3						
Previous Year 4						

2. a. Does your expiring Fiduciary Liability Insurance policy include Employee Benefits Liability (EBL) coverage? Yes No
- b. Does your expiring Commercial General Liability Insurance policy include Employee Benefits Liability (EBL) coverage? Yes No

If requesting prior acts coverage you will be asked upon binding coverage to provide a copy of your current insurance declaration page documenting the expiring retroactive date and limits. Prior acts coverage may not be available if the date of your current retroactive coverage is different from what we have quoted or if there is any gap between effective dates.

3. Are you being canceled or non-renewed by your current Fiduciary Liability carrier? Yes No

If Yes, please explain why: _____

4. Requested Limits: \$100,000/\$300,000 \$250,000/\$250,000 \$500,000/\$500,000 \$1,000,000/\$1,000,000
 Other \$ _____ /\$ _____

Requested Deductible (Per Claim): \$10,000 \$25,000 \$50,000 Other _____

5. After inquiry with each person as appropriate, has any Fiduciary or any Directors or Officers had a Fiduciary Liability claim or been alleged or found guilty of any Fiduciary breach of duty? Yes No

If "Yes", how many? _____ Please complete a separate Supplemental Claim Form for each claim or suit and include a currently valued loss run for each claim. Yes No

6. After inquiry with each person as appropriate, do you of any Fiduciary, or any of your partners, officers, directors, or employees know of any circumstances, acts, errors, omissions, or any allegations or contentions of any incident that could result in a Fiduciary Liability claim? Yes No

If "Yes," how many? _____ If "Yes," please complete a separate Supplemental Claim Form for each potential claim and provide as much details as possible.

REQUIRED ATTACHMENTS

Please furnish us with the following documentation *for each plan for which coverage is requested* in this policy:

- Currently valued 5-year Fiduciary Liability loss runs.
- Copy of plan and trust documents, and any amendments made thereto.
- Samples of enrollment, cancellation, dispute, or other forms used for the plans.
- Samples of recent newsletters or other written plan communication distributed to participants and beneficiaries.

- Most recent Form 5500.
- For any plan that is designed to invest primarily in securities, the most recent CPA-audited financial statements.
- For any plan (or plan feature) that is designed to primarily invest in securities of the Sponsor Organization, the most recent CPA-audited financial statements and a completed ESOP questionnaire for each plan.
- For any plan that filed for exemption from a prohibited transaction, a copy of the filing and the DOI response.
- Latest annual report for the Sponsor Organization.
- Latest interim financial statements for the Sponsor Organization.

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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 LOUISIANA 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.

NOTICE TO MAINE 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 may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 \$5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO 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 a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE 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 VIRGINIA 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.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____
(Must be signed by a Director of Human Resources or a current Fiduciary)

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____



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PLAN SUPPLEMENTAL APPLICATION

Complete one plan questionnaire for EACH plan for which coverage is being requested.

PART I: PLAN DETAILS

1. Name of plan to be covered: _____

Total assets (market value): \$ _____

2. Is the plan a Multi-Employer or Multiple Employer Plan? Yes No

3. Number of participants and beneficiaries of the plan: _____

4. ERISA Qualified Plan? Yes No

5. Type of Employee Benefit Plan: Welfare Defined Benefit Defined Contribution

6. List the names of all Fiduciaries **named** in the plan:

Administrator: _____

Investment Manager: _____

Directors and Officers: _____

Other Fiduciaries (list name/title/role to plan):

7. Does the plan hold any contract with a guaranteed return [including Guaranteed Investment Contracts (GICs), Guaranteed Annuity Contracts (GACs), or Bank Investment Contracts (BICs)]? Yes No

If yes, please attach complete details, including name of contract provider, the market value of the contract, and the date the contract expires.

8. If there is ERISA Fidelity Bond coverage in force with another Insurer, please indicate below. If no coverage is carried, check here .

- a. Insurer: _____
- b. Limit of Liability: _____
- c. Premium: _____

9. Has any ERISA Fidelity Bond for this plan ever been refused, canceled, or non-renewed? Yes No
(If yes, attach complete details.)

PART II: PLAN ADMINISTRATION

1. Does the plan employ the services of a Third Party Administrator? Yes No
(If yes, indicate the name of the organization and the services they provide to the plan.)

Actuarial: _____

Administrative: _____

Benefits Consulting: _____

Legal: _____

Trustee: _____

Other: _____

2. Does a non-employee Investment Manager manage all assets? Yes No

If yes:

How often is the Investment Manager's performance reviewed?

- Monthly Quarterly Semi-Annually Other (If other, please attach explanation.)

How often are the Investment Manager's guidelines for investment reviewed by the Fiduciaries?

- Semi-Annually Annually Bi-Annually Other (If other, please attach explanation.)

If no, or "only some" assets are invested by an Investment Manager, please attach a narrative explanation.

3. Has any Fiduciary of the plan been:

- a. The subject of any alleged breach of duty or other Fiduciary Liability Claim? Yes No
- b. Found guilty of a breach of duty? Yes No
- c. Found guilty under any criminal act enumerated in Section 411 of ERISA? Yes No
- d. Refused coverage under an ERISA Fidelity Bond? Yes No

If the answer to any of the above is yes, please complete a Fiduciary Liability Claim Supplemental.

4. Complete the following chart of professionals that currently work with the Applicant:

Type of Professional	Name of Person	Name of Company (or Employer)	Location (city)	Years working with plan
Risk Manager (or equivalent position)				
General Counsel				
Outside law firm for benefits and ERISA litigation				

5. Who controls the documentation about the plan that is distributed to participants and beneficiaries?

Is there a process to review documentation before it is distributed? Yes No
 (If yes, please attach a copy of the procedure or explain the process in an attachment.)

PART III: PLAN ACTIVITIES

1. Has the plan requested or contemplated filing a request for termination? Yes No
 (If yes, attach complete details.)

2. In the past two years, have there been any amendments to the plan, or has any amendment been contemplated, that has resulted in or may result in any change or reduction of benefits, including but not limited to an increase in participants' share of costs? Yes No
 (If yes, attach complete details.)

3. Has the plan or any portion of the plan been spun off (sold), transferred, or terminated?
 If no, check here .

If yes, attach complete details, including:

- Date of sale or termination
- Whether assets have been fully distributed or reverted to a party other than the plan participants
- Name of annuity provider, if benefits have been secured by annuities

4. In the last 12 months, has there been any merger, acquisition, restructuring, or consolidation of or by the Sponsor Organization, or any of its subsidiaries, that resulted in or may result in plan participants transferring to another plan, company, or subsidiary? Yes No

Is any such action being considered? Yes No

If yes for either question, attach complete details, including:

- Date (or expected date) of the transfer of benefits
- Copies of materials distributed (or to be distributed) to Employees relating to the transfer of benefits
- Most recent financial statements for any created or acquired subsidiaries

5. Has there been, or is there now pending, any claim(s) against any proposed Insured arising out of this plan? Yes No

(If yes, attach complete details.)

6. Does any proposed Insured have knowledge or information of any act, error, or omission, which might give rise to a claim under the proposed policy? Yes No
(If yes, attach complete details.)
7. Is there any known violation(s) of ERISA, or any similar common or statutory law of the United States, Canada, or any state or other jurisdiction anywhere in the world, to which the plan is subject? Yes No
(If yes, attach complete details.)
8. Has there been or is there now pending any inquiry, investigation, or communication which could give rise to a claim under this policy? Yes No
(If yes, attach complete details.)

PART IV: DEFINED BENEFIT PLANS

1. Questions that apply to Defined Benefit Plans ONLY. If this is NOT a Defined Benefit plan, skip to Part V:
- a. When did the plan's enrolled actuary last certify the plans Adjusted Target Funding Attainment Percentage (ATFAP)?
Date: _____
- b. Are there any overdue employer contributions for the plan, or has the plan requested or contemplated filing a request for a waiver of contributions? Yes No
(If yes, attach complete details, including the amount overdue.)
- c. Is the plan currently operating under a funding improvement/rehabilitation plan or subject to any benefit restrictions pursuant to the Pension Protection Act of 2006? Yes No
(If yes, attach complete details.)

PART V: DEFINED CONTRIBUTION PLANS

1. Is the plan a qualified 401 (k) plan? Yes No
(If yes, answer all questions below.)
- a. List the current investment options that are available to the participants of the plan, along with their respective risks:
- | Name of Investment Option | Level of Risk (Check One) | | |
|---------------------------|---------------------------|--------|------|
| | Low | Medium | High |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
- b. How often can participants typically make changes in the allocation of their investments in the plan?
 Quarterly Monthly Weekly Daily Other
 If other, please explain: _____

- c. Have there been any blackout periods in the past 12 months that prevented participants from making changes in the allocation of their investments? Yes No

If yes, list first date _____ and last date _____ of blackout period.

- d. Who provides investment guidance to the participants of the plan?

Name of Adviser: _____

Title of Adviser: _____

Company that employs the Adviser: _____

- e. How often is investment guidance made available to employees?

Annually Semi-Annually Quarterly Monthly Available upon request

If less than annually, please explain: _____

- f. Can participants choose to invest in employer stock in the 401 (k) plan? Yes No

If yes, what is the actual dollar value of plan assets invested in employer stock? _____

If yes, what is the limit to the percentage of assets that can be invested in employer stock?

No limit 10% 20% Other

If other, please explain: _____

- g. Does the company contribute any "matching funds" to the 401 (k) accounts? Yes No

If yes, how are the funds contributed? Cash Value Employer Stock Other

If other, please explain: _____

If matching funds are contributed in employer stock, are there restrictions that prevent the participant from moving that stock to another investment? Yes No

If yes, how long is the employee required to wait before moving the stock? _____

- h. Is any Fiduciary of this 401 (k) plan also a company Director, Officer, or Employee who has access to company financial statements and other financial information? Yes No

(If yes, attach complete details.)

2. Is the plan designed to invest primarily in employer securities? Yes No

(If yes, please complete and attach an ESOP Questionnaire to your application.)

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The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Signed: _____ Date: _____
(Must be signed by a current Fiduciary.)

Print Name: _____

Title: _____



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FIDUCIARY LIABILITY SUPPLEMENTAL CLAIM APPLICATION

- ***This form is to be completed when the Applicant has been involved in any claim or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM OR INCIDENT.***
- ***If space is insufficient to answer any questions fully, attach a separate sheet.***
- ***In lieu of attaching suit papers, please provide a complete narrative description of the allegations involved***

APPLICANT'S INFORMATION

1. Full Name of Applicant: _____
2. Full Name of Individual(s) or entity involved in the claim: _____
3. Name of the Plan(s) involved in the claim: _____
4. Additional defendants _____
5. Full Name of Claimant: _____
6. Is the Claimant still your client after bringing the claim? Yes No
Before or after this claim, did you perform other professional services for this Claimant unrelated to this claim? Yes No
If Yes to either question, please explain. _____
7. Before this claim, had you sued or otherwise pursued collection efforts against the Claimant for unpaid fees for your professional services? Yes No
8. Indicate whether: CLAIM SUIT Incident/Circumstance Only (no claim or suit)
9. Date and location of alleged act, error or omission: _____
10. Date of claim: _____ Date reported to Insurance Company: _____
11. What is the status of the claim? Closed/Settled Open/Pending Incident/Circumstance
12. IF CLOSED:

Total paid including deductible(s)? Responses such as "unknown" or "unavailable" are insufficient.

	Defense costs	Loss/compensatory damages
Paid by you-out of pocket	\$	\$
Insurance Company	\$	\$

Date Resolved: ____/____/____ Trial Out of Court

13. IF PENDING:

- (a) Claimant's settlement demand? \$ _____ Defendant's settlement offer (if any): \$ _____
- (b) Insurer's reserve amounts? Loss \$ _____ Defense \$ _____
- (c) Amounts already spent defending the claim? By you? \$ _____ By the insurer? \$ _____
- (d) What is your best estimate of the likely settlement amount for this matter? \$ _____
- (e) What is your best estimate of the date when you expect this claim to be resolved? _____

Note: Answering "unknown" or "unavailable" to the above questions is an insufficient response.

14. Name(s) of Insurer(s) responding to this claim or incident _____
 Policy Number: _____
 Limits of Liability: _____ Deductible: _____

15. Provide narrative description of suit, claim or incident, including the allegations involved, the potential size of injury and your response: _____

16. Explain what action(s) have been taken to prevent reoccurrence of a similar claim: _____

I declare that the information submitted herein is true to the best of my knowledge and becomes a part of my Professional Liability Application. I understand that an incorrect or incomplete statement could void my protection.

 Signature of Applicant/Title/Date

(Must be signed by a Principal, Partner or Officer of the Firm)

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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 LOUISIANA 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.

NOTICE TO MAINE 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 may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 \$5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO 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 a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE 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 VIRGINIA 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.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____
(Must be signed by a Principal, Partner, or Officer of the Firm)

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____