



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

## PRIVATE ORGANIZATION MANAGEMENT LIABILITY RENEWAL APPLICATION INCLUDING EMPLOYMENT PRACTICES AND FIDUCIARY LIABILITY

ANSWER ALL QUESTIONS. If not applicable, indicate N/A.

### REQUESTED RENEWAL COVERAGE

Available Coverage Section	Limit of Insurance Each Claim	Limit of Insurance Aggregate	Separate or Shared Limits of Insurance	Deductible	Retroactive Date	Prior or Pending Litigation Date
Directors & Officers Liability Coverage						
Employment Practices Liability Coverage						
Fiduciary Liability Coverage						

### 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 describe the nature of the Applicant's business: \_\_\_\_\_

\_\_\_\_\_

3. Please list all other business/dba names, including subsidiaries for which you are seeking coverage under this policy:

Name of Subsidiary	Business Type	% of Ownership	Date Acquired or Created	Private Co. or Nonprofit Org.

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. Primary location address: \_\_\_\_\_

6. County of primary location: \_\_\_\_\_ Date business originally established: \_\_\_\_\_

7. Type of Company:  Corporation  Partnership  LLC  JV  LLP  Other: \_\_\_\_\_

8. Total number of branches: \_\_\_\_\_ List all addresses for additional branches: \_\_\_\_\_

9. What is your web-site address? www. \_\_\_\_\_
10. 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
11. Does the Applicant have foreign operations? 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 12 months, has your name been changed or has any other business purchased, merged or consolidated with you? Yes  No

### ORGANIZATION INFORMATION

1. In the next 12 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 provide full details, 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
3. Does the Applicant manage or administer any entity (other than the Applicant Entity) under contract or agreement? *(If Yes, please provide full details.)* Yes  No
4. Does the Applicant currently carry General Liability Insurance? Yes  No
5. Does the applicant participate in any of the following activities:
- a. Franchising? Yes  No
- b. Joint Ventures? Yes  No

### DIRECTORS AND OFFICERS *(Complete only if renewing or applying for this coverage)*

1. Please attach a list of all members of the Board of Director's including name, affiliation and nomination date.
2. How many board meetings occur on an annual basis: \_\_\_\_\_
3. What is the total number of Applicant's voting shareholders: \_\_\_\_\_
4. What is the total number of shares owned by the Directors and Officers: \_\_\_\_\_  
Please list respective percentages of voting shares owned by D's and O's on a separate attachment.
5. Are there any shareholders (other than represented in (b) above) who hold more than 5% of the voting shares? *(If Yes, please provide details)* Yes  No
6. Have there been any changes to the applicants Board of Directors or key executives in the past 12 months? *(If Yes, please attach full details.)* Yes  No
7. Is the applicant contemplating any changes to the Board of Directors in the next 12 months? *(If Yes, please provide full details.)* Yes  No
8. Does the Applicant's charter or by-laws contain indemnification provisions? Yes  No

9. Does the Applicant or any Subsidiary perform any of the following services:

- a. Render any professional services or engage in any standard setting, accrediting, credentialing or licensing activities? *(If Yes, please provide full details.)*

Yes  No

**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	\$ _____	\$ _____
Total Liabilities	\$ _____	\$ _____
Total Revenues	\$ _____	\$ _____
Net Income (Net Loss)	\$ _____	\$ _____
Cash flow from Operations	\$ _____	\$ _____

2. Is the Applicant currently (or has it been in the past 12 months) in violation of, or has it received an amendment to any debt covenant? *(If Yes, please provide full details.)*

Yes  No

3. Does the Applicant or any Subsidiary have any plans to raise capital in the next 12 months? *(If Yes, please provide full details.)*

Yes  No

**EMPLOYMENT PRACTICES LIABILITY** *(Complete only if renewing or applying for this coverage)*

1. Employee Count:

- a. Full Time
- b. Part Time (include leased and seasonal)
- c. Independent Contractors
- d. Volunteers

Current Year	Previous Year
_____	_____
_____	_____
_____	_____
_____	_____

2. Salary Ranges  
*(including bonuses, dividends and commissions)*

Number of full time employees      Number of part time employees

\$50,000 or less:	_____	_____
\$50,001 to \$100,000	_____	_____
\$100,001 and over:	_____	_____
<b>TOTAL:</b>	_____	_____

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

	State:	State:	State:	State:	State:
Full-Time					
Part-Time					
Volunteers					

3. How many employees are covered by collective bargaining or other union agreements? \_\_\_\_\_

4. In the past 12 months, how many officers have left your employ? \_\_\_\_\_  
Of the above, how many were terminated? \_\_\_\_\_

5. In the past 12 months, how many other employees have left your employ? \_\_\_\_\_

Of the above, how many were terminated? \_\_\_\_\_

- a. 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 provide full details.)* Yes  No
- b. In the next twelve (12) months, do you anticipate the total number of 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 provide full details.)* Yes  No
- c. If during the next 12 months, circumstances of which are you currently unaware make it necessary for you to decrease the number of your employees by ten percent (10%) or five (5) employees, whichever is great, 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 provide full details.)* Yes  No
- d. Does the Applicant anticipate any merger, acquisition, or addition of any operations that would comprise a twenty-five percent (25%) or ten (10) employees, whichever is **greater**, increase over the current number of employees? *(If Yes, please provide full details.)* Yes  No
- e. Has any insurer ever cancelled or non-renewed the Applicant or its predecessor for this type of coverage? *(If Yes, please provide full details.)* Yes  No

## HUMAN RESOURCES

1. Does the Applicant have written employment agreements with all officers? Yes  No
2. Have the Applicant's managers and/or supervisors attended training and education programs/seminars on sexual harassment and other types of discrimination within the last 12 months? Yes  No   
If Yes, who has attended? \_\_\_\_\_  
If Yes, who conducts the sessions? \_\_\_\_\_
3. Does the Applicant have its employment policies/procedures reviewed by labor or employment counsel? Yes  No   
If Yes, identify the firm and date of last review: \_\_\_\_\_
4. Does the Applicant have a Human Resources or Personnel Department? Yes  No   
If No, who handles this function? \_\_\_\_\_
5. Does the Applicant have an employee handbook? Yes  No
- a. If Yes, any changes to the handbook in the last 12 months? Yes  No
- b. If Yes, does the Applicant distribute it to all employees? Yes  No
- c. If Yes, do all employees sign for its receipt? Yes  No
- d. If Yes, does it expressly state that it is not a contract and that employment is "at will"? Yes  No

6. Does the Applicant have written procedures for handling employee complaints of discrimination and/or sexual harassment? Yes  No
7. Does the Applicant require all terminations to be reviewed by:  
     The person in charge of human resources? Yes  No   
     Outside counsel? Yes  No
8. Does the Applicant maintain a personnel file for each employee? Yes  No

**THIRD PARTY INFORMATION**

1. Estimated number of employees with customer/client contact: \_\_\_\_\_
2. Please describe the frequency and nature of customer/client interactions. \_\_\_\_\_  
 \_\_\_\_\_
3. Has the Applicant or its predecessors ever received a complaint, formal or informal, from a non-employee, such as a customer, client, or prospective customer or client complaining about discrimination or harassment by the Applicant or any employee of the Applicant? Yes  No   
*(If Yes, please provide details on a separate sheet.)*
4. Does the Applicant conduct staff training on client and customer relations issues such as avoiding discriminatory behavior? Yes  No
5. Are there procedures for reporting and dealing with complaints by customers/clients? Yes  No
6. Is the Applicant in compliance with Title III of the Americans with Disabilities Act (building and premises requirements)? Yes  No

**FIDUCIARY LIABILITY** *(Complete only if renewing or applying for this coverage)*

Full Name of Plan	Total # of Participants	Active Number of Plan Participants	Total Plan Assets	Type of Plan*
			\$	
			\$	
			\$	
			\$	

Defined Contribution = DC; Defined Benefit = DB; Excess Benefit Plan = EB; Welfare Benefit Plan = WB; Employee Stock Ownership Plan = ESOP

1. Is any listed Plan a multiemployer or multiple employer plan? Yes  No   
 If yes please provide detail and if merger activity is anticipated. \_\_\_\_\_
2. Does the Applicant or any Subsidiary utilize a Plan investment manager? Yes  No   
 If so, what % of Plan assets are managed by the manager as defined by ERISA? \_\_\_\_\_
3. How often are plan guidelines and goals reviewed and/or amended by the fiduciaries? \_\_\_\_\_
4. Have any plans been spun-off, merged or terminated in the last 12 months? Yes  No
5. Does the Applicant or any Subsidiary expect any reduction in benefits, cessation of benefits, or increase in costs to plan participants as a result of any plan amendment anticipated in the next 12 months? Yes  No
6. Was any such amendment adopted within the last two years? Yes  No

**OTHER MATERIAL INFORMATION**

1. After inquiry with each person as appropriate does anyone have any other Material Facts to disclose? (If Yes, please provide such Material Facts on a separate sheet.) Yes  No

*A Material Fact is one likely to influence assessment of this risk, the premium charged or the terms and conditions imposed by Underwriters. If you are in any doubt as to whether a fact would be considered material, you should disclose it. All of the information requested in this proposal is material.*

**INSURANCE AND LOSS HISTORY**

1. After inquiry with each person as appropriate, in the last twelve (12) months, have any Directors & Officers claims, or any wrongful termination, discrimination, sexual harassment or any other wrongful employment practices liability claim or suit (including third party claims), or Fiduciary claims, ever been made against the Firm or any predecessor firm or any current or former member of the Firm or predecessor firm? 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.**

2. Of the total number of EEOC/state agency charges filed against any Applicant over the last five years, indicate the number of primary allegations as follows:

1) Location No.	2) Racial Discrimination	3) Age Discrimination	4) Religious Discrimination	5) Other Ethic Discrimination	6) Equal Pay Act Violation	7) Other Gender Discrimination	8) Violation of ADA

3. With respect to litigated cases (including wrongful termination suits under state law other than antidiscrimination law) and EEOC/state agency charges over the last five years for which any settlement was or may be paid, please provide the following information, which must be currently valued:

Date Occurrence	Claimant	Allegation	Damages Paid	Damages Reserved	Legal Expenses Paid	Legal Expenses Reserved

4. In the past 12 months, has the Applicant reported any new Directors & Officers, Employment Practices, or Fiduciary claims to a previous carrier including under any Extended Reporting Period/Tail Provision? 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.**

**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.**

## 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*):

- Most recent annual consolidated audited financial statement
- If requesting EPL, a copy of applicant's Employee Handbook
- If impact of Applicant layoffs is either 10% of the workforce or more than 100 employees, complete the Downsizing Supplemental Application.
- If requesting Fiduciary, provide the most recent audited statements for all plans. If exempt from filing audited statement, provide the most recent Form 5500 for each plan.

### 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.

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**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 applications.**

Applicant: \_\_\_\_\_ Title: \_\_\_\_\_  
(Must be signed by a Director of Human Resources or other  
Principal, Partner, or Officer of the Firm)

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent/Broker Name: \_\_\_\_\_





### PRIVATE MANAGEMENT LIABILITY SUPPLEMENTAL CLAIM APPLICATION INCLUDING EMPLOYMENT PRACTICES AND FIDUCIARY LIABILITY

- *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. Additional defendants \_\_\_\_\_
4. Full Name of Claimant: \_\_\_\_\_
5. 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. \_\_\_\_\_
6. Before this claim, had you sued or otherwise pursued collection efforts against the Claimant for unpaid fees for your professional services? Yes  No
7. Indicate whether:  CLAIM  SUIT  Incident/Circumstance Only (no claim or suit)
8. Date and location of alleged act, error or omission: \_\_\_\_\_
9. Date of claim: \_\_\_\_\_ Date reported to Insurance Company: \_\_\_\_\_
10. What is the status of the claim? Closed/Settled  Open/Pending  Incident/Circumstance
11. 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

12. 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.

13. Name(s) of Insurer(s) responding to this claim or incident \_\_\_\_\_  
 Policy Number: \_\_\_\_\_  
 Limits of Liability: \_\_\_\_\_ Deductible: \_\_\_\_\_

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

15. 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)

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

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent/Broker Name: \_\_\_\_\_