

**Designated Benefit Plan  
Fiduciary Liability Coverage  
Renewal Information Request**

Travelers Casualty and Surety Company of America

**NOTICE**

THE LIABILITY COVERAGE FOR WHICH APPLICATION IS MADE APPLIES, SUBJECT TO ITS 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. THE COMPANY HAS NO DUTY TO DEFEND ANY CLAIM UNLESS DUTY-TO-DEFEND COVERAGE IS SPECIFICALLY PROVIDED.

Answer each question on behalf of all entities seeking insurance coverage, unless specifically requested otherwise.

An Additional Information section is provided at the end of this document for any information that exceeds the space provided.

**GENERAL INFORMATION**

The term **Applicant** means all plans, trusts, organizations or other entities proposed for this insurance.

Name of <b>Applicant</b> :		Today's Date:
Street Address:		
Renewal Effective Date (mm/dd/yyyy):	Renewal Expiration Date (mm/dd/yyyy):	Expiring Policy Number

Information for Insurance Representative (the individual or entity designated by the **Applicant** to act as the **Applicant's** exclusive agent with respect to this insurance, including paying premiums and the giving or receiving of notices of cancellation, nonrenewal, or change of coverage):

Name of Insurance Representative:	
Street Address:	City, State, ZIP Code:

**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*):

- Financial statements for all trusts or plans
- Most recent 5500 of all ERISA plans
- Schedule of trust and plan trustees
- Sponsor financial statement if the **Applicant** is a multiple employer, government, or quasi-governmental plan

## TRUST/PLAN INFORMATION

1. Designated Benefit Plan Fiduciary Liability Coverage premium to be paid by trust or plan for which coverage is requested: .....  Yes  No

2. Complete the chart for all trusts or plans for which coverage is requested:

Full Trust or Plan Name	*Type	Current Asset Value	Latest FYE Annual Contributions	Current # of Participants	**Status
		\$	\$		
		\$	\$		
		\$	\$		
		\$	\$		
		\$	\$		

\* Types: Defined Benefit (DB) Defined Contributions (DC) Welfare Benefit Plan (W) Other (O) – Attach Explanation

\*\* Status: Active (A) Frozen (F) Terminated (T) (If any trust or plan has been terminated, indicate date of transaction)

List any additional trusts or plans in the Additional Information section at the end of this document.

3. Please provide name of firm(s) providing the following services:

CPA	Attorney	Actuary	Investment Advisor

4. Has the **Applicant** changed outside auditors in the last 12 months? .....  N/A  Yes  No  
*If yes, use the Additional Information section for explanation.*

## UNDERWRITING INFORMATION

5. Does any trust or plan not conform to the standards of eligibility, participation, vesting, blackout notification requirements or other provisions of ERISA or any similar or related federal, state, local, or foreign law or regulation governing employee benefits? .....  Yes  No  
*If yes, use the Additional Information section for explanation.*

6. Has any trust or plan:  
 (a) been the subject of an investigation by the DOL, IRS, or any similar state agency;  
 (b) had its tax exempt status withdrawn or threatened to be withdrawn by the IRS;  
 (c) filed for an exemption from a prohibited transaction; or  
 (d) received an adverse opinion as to its financial condition by an independent public accountant? .....  Yes  No  
*If yes, use the Additional Information section for explanation.*

7. If any trust or plan is a defined benefit trust or plan, has such trust or plan:  
 (a) experienced an event reportable to the PBGC;  
 (b) not been certified by an actuary to be adequately funded in accordance with the minimum funding standard of ERISA or any similar or related federal, state, local, or foreign law or regulation governing employee benefits; or  
 (c) been converted into a cash balance plan or is any such conversion expected in the next 12 months?  
 If there are no defined benefit trusts or plans, please check "N/A" .....  N/A  Yes  No  
*If yes, use the Additional Information section for explanation.*

8. Has any trust or plan:  
 (a) been amended within the last 12 months in a way that will result in the reduction of benefits or are any such amendments anticipated within the next 12 months; or

(b) been merged with another trust or plan or terminated within the past 2 years, or is any such merger or termination anticipated in the next 12 months? .....  Yes  No

*If yes, use the Additional Information section at the end of this document for explanation detailing the implementation, disclosure and any relevant blackout periods.*

9. Are there any outstanding or delinquent trust or plan contributions or trust or plan loans, leases or debt obligations that are in default or classified as uncollectible? .....  Yes  No

*If yes, use the Additional Information section for explanation.*

**INSURANCE TERMS INFORMATION**

10. Do you desire any changes to the expiring policy limit or retention? .....  Yes  No

*If yes, please indicate the desired changes in the table below:*

Expiring Limit (A)	Requested Limit (B)	Expiring Retention (C)	Requested Retention (D)
\$	\$	\$	\$

*Do not answer the next question unless the Requested Limit in Column (B) exceeds the Expiring Limit in Column (A).*

11. Solely with respect to the higher limits requested or that may ultimately be issued for the proposed renewal, 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 Designated Benefit Plan Fiduciary Liability Coverage? .....  Yes  No

*If yes, use the Additional Information section at the end of this document for explanation.*

*Solely with respect to any portion of the Limit for this proposed Designated Benefit Plan Fiduciary Liability Coverage that exceeds the amount of the Expiring Limit for this Designated Benefit Plan Fiduciary Liability Coverage in the expiring policy, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any natural person officer, including any executive director or functional equivalent thereof; member of the board of trustees; in-house risk manager; or in-house general counsel 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.*

**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](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.

This application, including any material submitted in conjunction with the application or any renewal, does not amend the provisions or coverages of any insurance policy or bond issued by Travelers. It is not a representation that coverage does or does not exist for any particular claim or loss under any such policy or bond. Coverage depends on the facts and circumstances involved in the claim or loss, all applicable policy or bond provisions, and any applicable law. Availability of coverage referenced in this document can depend on underwriting qualifications and state regulations.

**FRAUD STATEMENTS – Attention Applicants in the Following Jurisdictions:**

**ARKANSAS, DISTRICT OF COLUMBIA, 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.

**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.

**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.

**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.

**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.)

**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.

**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.

**SIGNATURES**

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (TRUSTEE OR FIDUCIARY) 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.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

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

Signature* of <b>Applicant's</b> Authorized Representative: (Trustee or Fiduciary) <b>X</b>	Authorized Representative Name - Printed:	Date:
Producer Signature*: <b>X</b>	State Producer License No. (required in FL):	Date:
Agency:	Agency Code:	Agency Phone Number:

\* If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you 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.

- Electronic Signature and Acceptance – Authorized Representative
- Electronic Signature and Acceptance – Producer

**ADDITIONAL INFORMATION**

This area may be used to provide additional information to any question. Please reference the question number.