



ULLICO ORGANIZED LABOR PROTECTION GROUP, LLC

a voluntary membership organization operating pursuant to the Liability Risk Retention Act of 1986 and whose principal office is: 8403 Colesville Rd, Silver Spring, MD 20910

Markel American Insurance Company
4521 Highwoods Parkway
Glen Allen, VA 23060

RENEWAL BUSINESS APPLICATION

Fiduciary Liability Claims-Made Policy

Important Information and Instructions:

1. All questions must be answered fully and completely. Please type or print clearly in ink. If a question does not apply to the Trust or Plan, state "Not Applicable" or "N/A."
2. All information identified in Section H (Required Attachments) must be submitted with this application.
3. If a single policy is desired for more than one Trust or Plan, please submit a separate application for each Trust or Plan.
4. The policy for which application is made is written on a claims-made basis. The coverage afforded by this policy is limited to liability for only those claims first made during the policy period specified on the Policy Certificate resulting from wrongful acts and which are subsequently reported to the Insurer as soon as practicable. This is a policy with claims expenses included in the Limits of Liability. Please read the policy carefully.
5. Please submit application and all required attachments to your Producer/broker.
6. Producer/broker, please submit application and all required attachments to:

EBERTS & HARRISON

Union Insurance by Union Agents

Eberts & Harrison, Inc

1604 Ridgeside Drive, Suite 203

Mount Airy, Maryland 21771

Phone: (301) 596-3940

Fax: (301) 596-5543

Christian@ebertsandharrison.com

Renewal Application

A. General Information

1. Name of Trust or Plan: _____

EIN Number(s): _____

State Trust or Plan is Domiciled: _____

2. Address of Trust or Plan: _____ Telephone No. _____

City: _____ State: _____ Zip: _____

3. Producer/Broker: _____

4. Address of Producer/Broker: _____ Telephone No. _____

B. Coverage Request

5. Renewal Effective Date: _____
 Month Day Year

6. Requested Limits of Liability: (Choose appropriate Limit(s))

(X)	Limit Each Claim/Aggregate Per Policy Period	(X)	Limit Each Claim/Aggregate Per Policy Period
	\$ 500,000 / \$ 500,000		\$ 8,000,000 / \$ 8,000,000
	\$ 1,000,000 / \$ 1,000,000		\$ 9,000,000 / \$ 9,000,000
	\$ 2,000,000 / \$ 2,000,000		\$10,000,000 / \$10,000,000
	\$ 3,000,000 / \$ 3,000,000		\$11,000,000 / \$11,000,000
	\$ 4,000,000 / \$ 4,000,000		\$12,000,000 / \$12,000,000
	\$ 5,000,000 / \$ 5,000,000		\$13,000,000 / \$13,000,000
	\$ 6,000,000 / \$ 6,000,000		\$14,000,000 / \$14,000,000
	\$ 7,000,000 / \$ 7,000,000		\$15,000,000 / \$15,000,000

C. Trust or Plan Information and Management

7. Provide total number of present Trustees and any employees of the Trust or Plan:

Trustees (including signatory to this application): _____

Employees (including inside administrators and all administrative/clerical staff): _____

- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| 8. In the past year has the name of the Trust or Plan been changed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. In the past year has any other trust or plan merged with or been merged into the Trust or Plan or is any anticipated to be merged with or into the Trust or Plan in the next twelve (12) months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. In the past year has there been any Trust or Plan amendments or do you anticipate any Trust or Plan amendments that will result in a reduction in benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the Trust or Plan been terminated or is termination anticipated in the next 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |

NOTE: If you answer YES to questions 8-11 above, you must provide a detailed, written narrative and pertinent documentation.

YES NO

12. Does the Trust or Plan have current coverage under an ERISA fidelity bond?
If **no**, please explain (attach additional pages as needed): _____

13. Have changes been made in any of the below service providers during the past year (1):

a. Third Party Administrator	<input type="checkbox"/>	<input type="checkbox"/>
b. Consultant/Actuary	<input type="checkbox"/>	<input type="checkbox"/>
c. Legal Counsel	<input type="checkbox"/>	<input type="checkbox"/>
d. Certified Public Accountant	<input type="checkbox"/>	<input type="checkbox"/>
e. Custodian of Assets	<input type="checkbox"/>	<input type="checkbox"/>
f. Investment Consultant/Manager	<input type="checkbox"/>	<input type="checkbox"/>

If **yes**, please provide details, including the name of the provider and years of service (attach additional pages as needed): _____

14. Does the Trust or Plan have a service agreement with any other trust(s) or plan(s) to provide or receive services of any kind (for example administrative, or collections/collection services)?

15. Does the Trust or Plan have a service agreement with a third party networking provider or cloud service to store Personally Identifiable Information?

If **no**, and the Trust or Plan uses these services please provide a detailed, written narrative and pertinent documentation of the type of service

16. Does the Trust or Plan have a security plan or procedures for mobile devices (e.g. laptops, USB flash drive, mobile phones, etc.) that contain Personally Identifiable Information?

D. Employment Practices Liability Coverage (Complete Section D. found in Addendum A only if this coverage is desired)

E. Professional Services Liability (Services provided for or to a Third Party, or services for which a Trust or Plan receives compensation or remuneration of any kind)
(Complete Section E. found in Addendum A only if this coverage is desired)

F. Joint Apprenticeship Training Committee (Complete Section F. found in Addendum A only if this coverage is desired)

G. Cyber Liability – Third Party Liability for Data Loss – Personal Injury Electronic Media Professional Liability arising out of Technical Professional Services (Complete Section G. found in Addendum A only if this coverage is desired)

H. Required Attachments

Provide the following material with respect to the Trust or Plan:

- 1. Latest audited annual financial statement OR latest Form 5500 / Form 990.**
- 2. Names of Trustees for all Trusts or Plans**

Additional information may be requested based on specific applicant characteristics.

FRAUD WARNINGS

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 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.

NOTICE TO KANSAS APPLICANTS: It is unlawful to knowingly commit a "fraudulent insurance act." Which is an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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 MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 NEW YORK APPLICANTS: 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 material false information, 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 civil penalty not to exceed five thousand dollars 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 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: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony." The absence of such a statement shall not constitute a defense in any prosecution.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to injure, deceive, defraud any insurer or other person files an application or a claim containing any false, incomplete or misleading information or conceals information concerning any material fact may be guilty of insurance fraud, which is a crime and may subject such person to criminal and civil penalties.

NOTICE TO TENNESSEE AND WASHINGTON 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 VERMONT APPLICANTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO APPLICANTS IN AR, FL, KY, MN, NJ, AND PA: 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.

NOTICE TO ALL OTHER APPLICANTS: Any person who knowingly and with intent to injure, deceive, defraud any insurer or other person files an application or a claim containing any false, incomplete or misleading information or conceals information concerning any material fact commits insurance fraud, which is a crime and subjects such person to criminal and civil penalties.

The undersigned represents, after inquiry, that to the best of his or her knowledge and belief the statements set forth herein are true, and he or she has not withheld any information which is reasonably likely to influence the judgment of Markel American Insurance Company in considering this application for fiduciary liability insurance. The undersigned further represents that if the information supplied by him or her on this application changes between the date of this application and the effective date of the insurance or the time when the policy is bound (whichever is later), the undersigned will immediately notify Markel American Insurance Company in writing of such changes and the insurer may withdraw or modify any outstanding quotations based upon such changes. The signing of this application does not bind the insurer to complete the insurance, but it is agreed that this application and any attachments form the basis of the contract should a policy be issued and shall be deemed attached to and form part of a policy. Markel American Insurance Company is hereby authorized to make any investigation and inquiry in connection with this application it deems necessary.

Signature of Trustee or Authorized Representative: _____

Date: _____

Print Name: _____

Title: _____

Email Address: _____

**Ullico Organized Labor Protection Group, LLC is administered by Ullico Casualty Group, Inc., a/k/a Ullico Insurance Agency, Inc. in CA, and Ullico Casualty Agency in NY. CA License #OH86030 and FL (Craig Arneson) License # A008437.

EBERTS & HARRISON

Union Insurance by Union Agents

Eberts & Harrison, Inc

1604 Ridgeside Drive, Suite 203

Mount Airy, Maryland 21771

Phone: (301) 596-3940

Fax: (301) 596-5543

Christian@ebertsandharrison.com

ADDENDUM A

**PLEASE NOTE: BELOW ARE OPTIONAL COVERAGES THAT CAN BE ADDED TO YOUR CURRENT POLICY
 ONLY COMPLETE IF INTERESTED IN THE ADDITIONAL COVERAGES
 PLEASE CALL 301-596-3940 WITH ANY QUESTIONS**

D. Employment Practices Liability Coverage (Complete this section D. only if Employment Practices Liability coverage is desired)

Requested Sub-Limit:

(X)	Sub-Limit per Policy Period	(X)	Sub-Limit per Policy Period
	\$ 100,000		\$ 500,000
	\$ 250,000		\$ 1,000,000

Defense and Indemnity _____ Defense Only _____

1. Employment Practices Liability Insurance has been continuously in force since: _____
2. Please provide the following employee count information for the past two years:

Employees of the Trust or Fund	Current Year (12 months):	Prior Year:
Full-Time:		
Part-Time :		
Temporary:		
Volunteers:		
Total		

3. How many employees have been terminated, demoted, or suspended in the past 12 months?
 - a. Voluntary _____
 - b. Involuntary _____
 - c. Laid Off _____
 - d. Demoted _____
4. Is any reduction of employees or change in status anticipated in the next year?
 - a. Voluntary _____
 - b. Involuntary _____
 - c. Laid Off _____
 - d. Demoted _____

NOTE: If there have been any terminations, demotions or suspensions in the past 12 months or any planned for the next year provide a detailed and written narrative (attach additional pages as needed).

- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| 5. Does the Trust or Fund have an employment handbook? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does the Trust or Fund use an employment application for every potential employee? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the Trust or Fund implemented an anti-sexual harassment policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has the Trust or Fund implemented an anti-discrimination policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does the Trust or Fund use counsel for employment advice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do employees have a method to report grievances? | <input type="checkbox"/> | <input type="checkbox"/> |

NOTE: If you answer NO to questions 5-10 above, you must provide a detailed, written narrative.

E. Professional Services Liability (Complete this section E. only if Professional Services Liability coverage is desired)
 (Services provided for or to a Third Party, or services for which a Trust or Plan receives compensation or remuneration of any kind)

1. Describe the service being offered:

2. Specify the number of Trust's or Plan's employees who are providing the service. _____
3. Annual Revenues generated from service(s), if any _____
4. Number of annual recipients of service(s), if any _____

