Instructions for Using the St Paul Travelers Electronic WRAP+ Stand-Alone Coverage Part Application

1. Maneuver through the application utilizing the tab key or your cursor. A blank page, after the Signature section, has been included with this application to capture any of your responses if you need additional space.

2. Please save or print the document for your records, then forward with all required supporting materials to your insurance representative for a quote. To bind coverage simply print the Signature Page, have it signed and dated by the President or CEO and mail or fax to your insurance representative.

If you encounter problems completing the application or need to clarify what information must be submitted with the application, please contact your insurance representative. If you are an agent or broker, please contact your local St Paul Travelers Executive Liability representative.

Begin

Agency	Code	Agent Name/License Number	Policy Number

Applicant Information:

Name of **Applicant**: _____

Year **Applicant's** Business Was Established: _____

Street Address: _____

City, State, Zip: _____

Website Address: _____

Description of **Applicant's** Operations:

Does the **Applicant** now have tax exempt status under the United States Internal Revenue Code? Yes ☐ No ☐

Is the **Applicant** a subsidiary of a foreign parent? Yes ☐ No ☐

Does the **Applicant** currently file, or do they anticipate in the next 6 months filing, any documents with the Securities and Exchange Commission, or similar foreign authority regarding any equity or debt securities? Yes ☐ No ☐

CONTACT INFORMATION FOR RISK MANAGEMENT SERVICES

The policy for which this application is made includes Risk Management Plus+ Online℠, a loss prevention program. Please provide the name and contact information for the individuals responsible for overseeing Financial and Human Resource matters for access to the program. This service is not, and should not be, considered a substitute for competent legal counsel. Any recommendations should be reviewed with appropriate legal counsel before implementation.

HR Contact: _____ HR Contact Email: _____

Title: _____ HR Contact Phone: _____

Chief Financial Officer: _____ CFO Contact Email: _____

Preferred Title: _____ CFO Contact Phone: _____

EMPLOYEE INFORMATION

Maximum number of employees at any one point during the previous 12 months for the following classifications (regardless of whether they are full or part time):

Employees	Leased	Labor Unions	Independent Contractors	Temporary

FINANCIAL INFORMATION

Note: Omit this section if the Applicant is required to submit a separate financial statement as directed in the Required Attachments section.

Please indicate the following as it relates to the Applicant's fiscal year end (FYE): *(please indicate negative figures with "( )" or "-", as appropriate)*	**Most Recent FYE (Month/Year)** /	**Prior FYE (Month/Year)** /
1. Current Assets		
2. Total Assets		
3. Current Liabilities		
4. Long Term Debt		
5. Retained Earnings/Fund Balance (Accumulated Deficit/Fund Deficit)		
6. Net Equity/Net Assets (Deficit Equity)		
7. Revenues		
8. Net Income (Net Loss)		
9. Is the **Applicant** currently, or has it been in the past 24 months, in violation or has it amended any debt covenant? **If "Yes", please attach an explanation**		Yes ☐ No ☐

PLAN DATA

Premium to be Paid By: Employer or Union ☐ Trust or Plan ☐	
Total Number of Plan Fiduciaries:	

Complete Chart for all plans for which coverage is requested:

Full Plan Name	*Plan Type	Current Asset Value	Latest FYE Annual Contributions	Current No. of Participants	**Plan Status

***Plan Types: Defined Benefit (DB) Defined Contributions (DC) ESOP (E) Self-Funded Welfare Benefit Plan (W) Other (O) – Attach Explanation**

****Plan Status: (A)=Active (F)=Frozen (S)=Sold (T)=Terminated (if any plan has been terminated, indicate date of transaction)**

List additional plans on a separate attachment

PLAN UNDERWRITING QUESTIONS

1. Is each plan reviewed periodically to assure there are no violations of ERISA (e.g., prohibited transactions or party-in-interest rules)? **If "No", please attach an explanation** Yes ☐ No ☐
2. Does any plan (a) not conform to the standards of eligibility, participation, vesting, blackout notification requirements and other provisions of ERISA or similar foreign law; (b) hold employer securities or employer real property in violation of ERISA or in excess of ERISA limits; or (c) invest in or provide an option to invest in employer securities? **If "Yes", please attach an explanation** Yes ☐ No ☐
3. Has any plan (a) been the subject of an investigation by the DOL, IRS, or any similar foreign agency; (b) had its tax exempt status withdrawn or threatened to be withdrawn by the IRS; (c) experienced an event reportable to the PBGC; (d) filed for an exemption from a prohibited transaction; (e) received an adverse opinion as to its financial condition by an independent public accountant; or (f) not been certified by an actuary to be adequately funded in accordance with ERISA's minimum funding standard? **If "Yes", please attach an explanation** Yes ☐ No ☐
4. Does the **Applicant** sponsor any Cash Balance Plans or does the **Applicant** anticipate the conversion to or has it ever converted a pension plan to a Cash Balance Plan? **If "Yes", please attach an explanation** Yes ☐ No ☐
5. Has any 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 plan, terminated or sold within the past two years or anticipated in the next 12 months? **If "Yes", please attach an explanation detailing whether a blackout period will result and any associated plans for implementation and disclosure to participants** Yes ☐ No ☐

6. Are there any outstanding or delinquent plan contributions or plan loans, leases or debt obligations that are in default or classified as uncollectible? **If "Yes", please attach an explanation** Yes ☐ No ☐

7. Does the employer, committee or employer representatives, or union board of trustees have final say over the determination of whether benefits will be paid under any healthcare plan sponsored by this Insured? **If "Yes", please identify the names of such plans in a separate attachment** Yes ☐ No ☐

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

CPA	Attorney	Actuary	Investment Advisor

POLICY OPTIONS

What is the **Applicant's** preference for defense coverage? Duty to Defend ☐ Reimbursement ☐

CURRENT INSURANCE INFORMATION/REQUESTED INSURANCE TERMS

Requested Limit (A)	Requested Retention (B)	Requested Effective Date (C)	Coverage Currently Purchased (D)	Expiring Limit (E)	Expiring Retention (F)	Expiring Premium (G)	Current Insurer (H)	Date Coverage First Purchased (I)
			Yes ☐ No ☐					

1. **If Liability Coverage is currently purchased as indicated in column (D) above, please answer the following question:**
   As of the Date the **Applicant** first purchased this Liability Coverage, were there any facts, circumstances, or situations which might have resulted in a claim being made against any insured? Yes ☐ No ☐
   If "Yes", please attach an explanation
   (Not applicable if coverage first purchased and continuously maintained more than 3 years prior to this application date)

2. **If Liability Coverage is not currently purchased as indicated in column (D) above, please answer the following question:**
   Are there any facts, circumstances, or situations which could give rise to a claim under the Liability Coverage for which the **Applicant** is applying? Yes ☐ No ☐
   If "Yes", please attach an explanation

3. **With respect to the Liability Coverage being applied for above, if Requested Limit of Liability in Column (A) exceeds the Expiring Limit of Liability in Column (E):**
   With respect to the higher limits requested, are there any facts, circumstances, or situations which could give rise to a claim under the Liability Coverage for which the **Applicant** is applying? Yes ☐ No ☐
   If "Yes", please attach an explanation

Without prejudice to any other rights and remedies of the Company, any claim arising from any facts or circumstances required to be disclosed is excluded from the proposed insurance.

LOSS INFORMATION

In the past three (3) years, whether or not insured, has any plan, **Applicant**, entity or person proposed for this insurance been accused or found guilty of any criminal act or been accused of, found guilty of or held liable for a breach of fiduciary duty, or a violation of ERISA, or any similar state, local or foreign law or have any ERISA-related claims, administrative or regulatory proceedings, charges, hearings or demands been made? **If "Yes", please complete the table below** Yes ☐ No ☐

To the extent that any lawsuit or claim required to be disclosed in response to the question above constitutes a "Claim" as defined by the Policy, such claim was made prior to the policy period requested hereunder and therefore would be excluded from coverage.

Details	Amount Paid for Defense	Amount Paid for Damages	Covered by Insurance?	Corrective Procedures Implemented
	$	$	Yes ☐ No ☐	
	$	$	Yes ☐ No ☐	

REQUIRED ATTACHMENTS

- Sponsor financial statement if **Applicant** maintains a defined benefit, self-funded welfare plan, an Employee Stock Ownership Plan (ESOP) or if the **Applicant** is a church, government or quasi-governmental entity
- Plan financial statements for defined benefit plans and self insured welfare plans, if limit requested is greater than $1,000,000
- Sponsor financial statement and plan financial statements for each defined contribution plan, if limit requested is greater than $5,000,000
- ESOP Questionnaire, if any plan is an ESOP or if any plan has 10% or more of plan assets invested in employer securities
- Most recent Form 5500 for each self funded welfare plan or union/Taft-Hartley plan
- Schedule of plan trustees for each union/Taft-Hartley plan and any church, governmental or quasi-governmental plan

SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED ST. PAUL TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY ST. PAUL 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: (1) IN VA AND UT, PHYSCIALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED; AND (2) IN ALL STATES OTHER THAN VA 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 IN CONNECTION WITH THE APPLICATION PROCESS, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Attention: Insureds in AR, CO, DC, FL, KY, LA, ME, NJ, NM, NY, OH, OK, PA, TN, and VA
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 may also be subject to a civil penalty.

(In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation.)

(In Colorado, 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.)

(*In 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 or concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.)*

(In 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.)

Signature of **Applicant's** Authorized Representative (President or CEO): _____ Title: _____

Name (Printed): _____ Date: _____

ADDITIONAL INFORMATION

This page may be used to provide additional information to any question on this application. Please identify the Section and Question Number (e.g., Financial Information, #9).

IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: 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.