



ExecProsm
Proposal Form
for
Fiduciary Liability Insurance

THIS IS A CLAIMS MADE POLICY, READ IT CAREFULLY
FIDUCIARY PROPOSAL FORM

Name of Company: _____

Street Address: _____

City, State, Zip: _____

Internet Website Address: _____

Please list the officer designated as agent of the Company and of all proposed Insureds to receive any and all notices from the Insurer or its authorized representatives concerning this insurance:

Name _____ Title _____

EMPLOYEE INFORMATION

1. Number of: Full-time employees _____; Part-time employees _____.
2. Does the Company make use of independent contractors or non-employee labor? ☐ Yes ☐ No
If "Yes", provide the number of such workers used in the last 12 months _____

EMPLOYEE BENEFIT PLAN INFORMATION

3. Provide the name, type of plan, total asset value and /or the total annual contributions and number of participants (active and retired or separated) for **all** Employee Benefit Plans of the Company for which coverage is sought including deferred compensation plans whether intended to be covered by ERISA or not. (Use form attached to this Proposal Form).
4. Does any plan or trust hold any "employer securities" as defined by ERISA? ☐ Yes ☐ No
If "Yes":
(a) List each plan and the percentage of the Company's securities held by each such plan or trust? _____

(b) Is the trustee of each such plan independent of the Company? ☐ Yes ☐ No
(c) If a private company, how often and by what method is the stock valued? _____

(d) Who has the voting rights for the shares of stock in the plan or trust? _____

5. Does any plan employ the services of:
(a) An investment management or consulting firm? ☐ Yes ☐ No
(b) A certified public accounting firm? ☐ Yes ☐ No

(c) An outside law firm?

☐ Yes ☐ No

(d) An actuarial firm?

☐ Yes ☐ No

If “Yes”, to any of (a) – (d), provide the name of each firm used by each plan: _____

If “Yes”, to (d), provide:

date of latest actuarial assessment: _____

did the assessment contain qualifications?

☐ Yes ☐ No

If “Yes”, attach a copy of the assessment.

were all the criticisms in the assessment corrected?

☐ Yes ☐ No

If “No”, attach an explanation.

6. If any plan does not employ the services of an independent investment manager, who is responsible for the investment decisions of that plan?

7. Are any plan benefits secured by insurance?

☐ Yes ☐ No

If “Yes”, describe the types of insurance and the carrier(s) providing such insurance: _____

PLAN CHANGES

8. In the past three years:

(a) Has any plan been consolidated or merged into any plan for which coverage is sought?

☐ Yes ☐ No

(b) Has there been any amendment to any plan that has resulted in a change or reduction in benefits to participants including the change to a cash-balance plan?

☐ Yes ☐ No

If “Yes”, provide details.

(c) Has the Company or any Subsidiary engaged in any transaction which caused any other entity to become the sponsoring employer of any employment Benefit plan, or which caused employees of the Company or any Subsidiary to become covered by a different Employee Benefit Plan, or which resulted in the termination of any Employee Benefit Plan?

☐ Yes ☐ No

If “Yes”, provide details including the date of such transaction, the date of any asset distribution or transfer, whether benefits were secured through the purchase of annuities, guaranteed investment contracts or other similar investments, and, if so, the name of the investment sponsor, and whether any plan assets reverted to any party other than plan participants.

9. Does the Company or any Subsidiary expect any of the events set forth in question 8. above to occur in the next 12 months?

☐ Yes ☐ No

If “Yes”, provide details.

COMPLIANCE

10. Do the persons responsible for plan administration meet regularly to conduct plan business, review performance of outside service providers and review claims under the plan? How often? _____

☐ Yes ☐ No

11. Does each plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), comply

☐ Yes ☐ No

with the requirements of ERISA relating to eligibility, participation, vesting, funding and all other matters?

If “No”, provide details.

12. At any time during the last five years has any plan had a funding deficiency? ☐ Yes ☐ No
13. At this time are there any delinquent contributions? ☐ Yes ☐ No
14. In the past 5 years, has there been any “reportable event” as defined in ERISA with respect to any plan? ☐ Yes ☐ No
15. Are there any transactions involving plan assets involving anyone known to be a party-in-interest? ☐ Yes ☐ No
16. Has any plan(s) invested in more than 10% of any corporation or partnership? ☐ Yes ☐ No

If “Yes” to any question 12. – 16., provide details.

17. Has the Company in the past, or does the Company anticipate in the next 12 months, allowing for enhanced benefits to employees electing early retirement if elected during a specified time period? ☐ Yes ☐ No

If “Yes”, provide details including whether such plans have been disclosed to all employees.

PRIOR ACTIVITIES

18. Have there been during the last five years, or are there now pending, any claims or suits brought against the plan(s), Sponsor Organization or its Subsidiaries, or any person proposed for this insurance which would have been covered by insurance similar to that applied for? ☐ Yes ☐ No

If “Yes”, provide details in an attachment to this Proposal Form.

IT IS AGREED THAT ANY CLAIM ARISING FROM ANY PRIOR OR PENDING PROCEEDING IS EXCLUDED FROM THE PROPOSED COVERAGE.

19. Is the undersigned or any other person(s) proposed for this insurance aware of any fact, circumstance or situation involving the Sponsor Organization, its Subsidiary(ies), the plan(s) or any other person proposed for this insurance, which he or she has reason to believe might result in any future claim which would fall within the scope of the proposed insurance? ☐ Yes ☐ No

If “Yes”, provide details in an attachment to this Proposal Form.

IT IS AGREED THAT IF KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION EXISTS, ANY CLAIM SUBSEQUENTLY ARISING THEREFROM SHALL BE EXCLUDED FROM COVERAGE.

PRIOR INSURANCE

20. Previous Employee Pension/Welfare Benefit Plan Fiduciary Liability Insurance (answer each item):

(a) Carrier _____

(b) Limit _____ Deductible _____ Policy Period _____ Premium _____

(c) Has any Claim been made or has notice been given to any Insurer? ☐ Yes ☐ No

(d) Has any carrier refused, cancelled or non-renewed coverage? ☐ Yes ☐ No

(e) If cancelled or non-renewed, has the discovery option been exercised? ☐ Yes ☐ No

If “Yes” to any of the above, please provide details in an attachment to this Proposal Form.

NOTICE TO ARKANSAS 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 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 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 reported by the applicant.

NOTICE TO FLORIDA APPLICANTS: 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.

Also provide: Agent name _____ License number _____

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 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 a denial of insurance benefits.

NOTICE TO NEW MEXICO 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 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 YORK 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 and fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars (\$5,000.00) and the stated value 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: WARNING: 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.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.

NOTICE TO TENNESSE 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.

NOTICE TO 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 include imprisonment, fines and denial of insurance benefits.

The undersigned Plan Administrator(s) and Officer of the Sponsor Organization on behalf of the Sponsor Organization, Plan(s) proposed and any other person(s) proposed for this insurance declare that to the best of their knowledge the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Proposal Form. The undersigned further agree that if any significant adverse change in the condition of the applicant is discovered between the date of this Proposal Form and the effective date of the Policy, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the Insurer immediately. The signing of this Proposal Form does not bind the undersigned to purchase the insurance.

It is agreed by the Company and the persons proposed for this insurance that the particulars and statements contained in this Proposal Form and any information provided herewith (which shall be on file with the Insurer and be deemed attached hereto as if physically attached hereto) are the basis of this Policy and are to be considered as incorporated in and constituting a part of this Policy. It is further understood and agreed by the Company and the persons proposed for this insurance that the statements in this Proposal Form or any information provided herewith are their representations, they are material and this Policy is issued in reliance upon the truth of such representations; provided, however, that except for material facts or circumstances known to the persons who subscribed this Proposal Form, any misstatement or omission in this Proposal Form or information provided herewith in respect of a specific Wrongful Act by a particular person proposed for this insurance or his or her cognizance of any matter which he or she has reason to believe might afford grounds for a future Claim against him or her shall not be imputed to any other person proposed for this insurance for purposes of determining the validity of this Policy as to such other person proposed for this insurance.

This Proposal Form must be signed by the Chairman of the Board, President, Chief Executive Officer, Chief Operating Officer, or Chief Financial Officer of the Company and by a Plan Administrator.

_____ Signature (Senior Officer)	_____ Title	_____ Date
_____ Signature (Plan Administrator)	_____ Title	_____ Date

Please submit one copy of each of the following documents:

- (a) The most recently filed Form 5500 and schedules for all Plans listed in the response to Question 1;
- (b) The most recent audited financial statements for each Plan;
- (c) The most recent annual report of the Sponsor Company;
- (d) If applicable, any required attachments in response to questions on this Proposal Form.

NOTE: The above materials are considered part of the Proposal Form.

This Proposal including any material submitted herewith shall be treated in strictest confidence.

Please submit this Proposal Form including appropriate documentation to:
Great American Insurance Companies, Executive Liability Division, P.O. Box 66943, Chicago, IL 60666

ATTACHMENT TO PROPOSAL FORM FOR FIDUCIARY LIABILITY INSURANCE

Question 3.

	PLAN NAME	TYPE	\$ ASSETS	\$CONTRIBUTIONS	# PARTICIPANTS	
					Active	Retired or Separated
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____	_____

TYPE OF PLAN:

WB = welfare benefit

DC = defined contribution

DB = defined benefit

O = other



FINANCIAL SUPPLEMENT for Fiduciary Liability
(for Companies with <100 participants)

INSURED _____

	<u>CURRENT YEAR ()</u>	<u>PREVIOUS YEAR ()</u>
TOTAL DEBT	_____	_____
DEBT DUE WITHIN TWELVE MONTHS	_____	_____
SHAREHOLDER EQUITY	_____	_____
REVENUES	_____	_____
NET INCOME	_____	_____
WORKING CAPITAL (CURRENT ASSETS LESS CURRENT LIABILITIES)	_____	_____

Note: This Supplement including any material submitted herewith shall be treated in strictest confidence.

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