# ACE Westchester Advantage[SM]
# Not-For-Profit Company Management Liability Insurance
# Renewal Application

## Instructions for Completing This Application

Please read carefully and check below all Coverages you seek. Fully answer all questions and submit all requested information only for each Coverage you seek. All applicants must complete the General Information and the final section of this Application. Terms appearing in bold face in this Application are defined in the Policy and have the same meaning in this Application as in the Policy.

## GENERAL INFORMATION

1. a. Name of the “Company” or “Applicant”:
   Street Address:
   City:
   State:
   Zip Code:

   b. Officer designated to receive correspondence and notices from the Insurer:

   ______________________________________________________________
   (Name of Officer) (Title)

   c. Officer or person responsible for Human Resource matters of the Company: this information required for employment loss control service that will be offered with your indication.

   ______________________________________________________________
   (Name of Person) E-mail address Phone Number

2. Tax Status: ☐ Section 501(c) ☐ Taxable Non-Profit
   ☐ Other (if other please describe)_________________________________________

***Information Required:***

- ***Most recent year end audited financial statements including all notes and schedules***
- ***Copy of the Applicant’s latest EEO1 report (required if Applicant has more than 100 employees);***
- ***Copy of the latest form 5500 and audited plan financials if Fiduciary Liability Coverage is sought.***

***Not-For-Profit Company Management Liability Coverage (complete only if the Applicant desires to renew this coverage):***

***Please answer the following questions*** (If “Yes”, please attach details).

1. What professional services does the Company and its **Subsidiaries** provide?

2. Has the **Company** or any of its **Subsidiaries**:

a. contemplated or been involved in any bankruptcy proceedings? ☐ Yes ☐ No

b. plan to declare bankruptcy within the next 12 months? ☐ Yes ☐ No

***Employment Practices Liability Coverage (complete only if the Applicant desires to renew this coverage):***

| | Full Time | Part Time/Other | Independent Contractors | Leased Employees |
|---|---|---|---|---|
| 1. Number of current employees: (Company and all **Subsidiaries**) | ________ | ________ | ________ | _______ |
| a. Turnover | ________% | | | |

2. Has the Company, or any of its **Subsidiaries**, had in the past twelve (12) months or do they contemplate within the next twelve (12) months having any layoffs, staff reductions, facility closings or consolidations? If "Yes," attach details. ☐ Yes ☐ No

***Fiduciary Liability Coverage (complete only if the Applicant desires to renew this coverage):***

1. Does any Defined Benefit Pension Plan have a funding deficiency? ☐ Yes ☐ No
(If "Yes", please attach details)

Plan Type ______________________ Current Balance __________________

This Application shall be maintained on file by the Insurer, shall be deemed attached as if physically attached to the proposed Policy and shall be considered as incorporated into and constituting a part of the proposed Policy.

By signing this Application, the Applicant warrants to the Insurer that all statements made in this Application, including attachments, about the Applicant and its operations are true and complete, and that no material facts have been misstated or concealed in this Application, or such attachments. The undersigned agrees that if after the date of this Application and prior to the effective date of any Policy based on this Application, any occurrence, event or other circumstance should render any of the information contained in this Application or attachments inaccurate or incomplete, then the Applicant shall notify the Insurer of such occurrence, event or circumstance and shall provide the Insurer with information that would complete, update or correct such information. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Insurer.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Insurer under any policy of a **Claim** or potential **Claim**. All such notices must be submitted to the Insurer pursuant to the terms of the Policy, if and when issued.

Signing of this Application does not bind the Insurer to offer nor the Applicant to accept insurance, but it is agreed that this Application shall be a basis of the insurance and it will be attached and made a part of the Policy should a Policy be issued. The Applicant's acceptance of the Insurer's quotation is required before the Applicant may be bound and a Policy issued.

The undersigned acknowledges that he or she is aware that **Defense Costs** reduce and may exhaust the applicable Limits of Liability. The Insurer is not liable for any **Loss** (which includes **Defense Costs**) in excess of the applicable Limits of Liability.


Copyright © 2009

**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 provided by the applicant.

**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 MARYLAND APPLICANTS:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 MINNESOTA APPLICANTS:** A person who submits an application or files a **Claim** with intent to defraud or helps commit a fraud against an **Insurer** is guilty of a crime.

**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 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 shall also be subject to a 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:** 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 TENNESSEE 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 purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**NOTICE TO ALL APPLICANTS:**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**


Copyright © 2009

This portion of the Application must be signed by the Chairman of the Board or by the President.

Signed: ______________________________

Title:

Date: ______________________________

**A POLICY CANNOT BE ISSUED UNLESS THE APPLICATION IS PROPERLY SIGNED AND DATED.**

Please submit this Application, when completed, signed and dated to:

ACE Westchester Specialty Group
Professional Risk Division
500 Colonial Center Parkway, Suite 200
Roswell, GA 30076

**FOR IOWA APPLICANTS ONLY:**

**Broker:**

**Address:**

**FOR MISSOURI RESIDENTS ONLY:**
**PLEASE ACKNOWLEDGE AND SIGN THE FOLLOWING DISCLOSURE TO YOUR APPLICATION FOR INSURANCE:**

**I UNDERSTAND AND ACKNOWLEDGE THAT THE ATTACHED POLICY CONTAINS A DEFENSE WITHIN LIMITS PROVISION WHICH MEANS THAT DEFENSE COSTS WILL REDUCE MY LIMITS OF INSURANCE AND MAY EXHAUST THEM COMPLETELY. SHOULD THAT OCCUR, I SHALL BE LIABLE FOR ANY FURTHER LEGAL DEFENSE COSTS AND DAMAGES.**

Signed: ______________________________
Must Be Signed By An Officer of Applicant

Title:

Date: ______________________________


Copyright © 2009