Carolina Casualty Insurance Company

NonProfit ExecShield®

Insurance Application

THIS APPLICATION IS FOR A CLAIMS MADE POLICY. THIS POLICY PROVIDES COVERAGE ON A CLAIMS MADE AND REPORTED BASIS. SUBJECT TO ITS TERMS, THIS POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS AND REPORTED TO THE INSURER DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD THAT MAY APPLY.

Whenever printed in this **Application**, the terms in boldface type shall have the same meanings as indicated in the **Policy**. This **Application** is to be completed with respect to the entire **Insured Entity**. **Insured Entity** as used herein is defined to include the **Named Insured** and any **Subsidiaries**. Additional space for responses is provided on the last page of the application.

Named Insured

Street Address | Suite

City | County | State | Zip Code

Website Address (if applicable) | Federal Employer Identification Number (FEIN)

The Officer designated as agent of the **Insured Entity** and of all **Insureds** to receive any and all notices from the **Insurer** or their authorized representatives concerning this insurance:

Contact Name | Title

E-mail Address | Telephone Number | Fax Number

Producer Information

Submitted by (Agency Name) | Dated

Agent's Name (Individual's Name) | Agent's License Number

Current Insurance Information

1. Provide the following information regarding the **Insured Entity's** most recent insurance policies. If "None", check box.

Type of Policy		Insurance Carrier	Expiration Date	Limit of Liability	Deductible	Premium
Directors and Officers Liability:	❑ None			$	$	$
Employment Practices Liability:	❑ None			$	$	$
Fiduciary Liability:	❑ None			$	$	$
Cyber Liability/Data Breach:	❑ None			$	$	$

2. Within the last 5 years, has any **Claim** been made or has notice been given under any of the previous policies for Directors and Officers Liability, Employment Practices Liability or Fiduciary Liability insurance or similar insurance? ❑ Yes ❑ No

3. Within the last 5 years, has any Directors and Officers Liability, Employment Practices Liability, Fiduciary Liability insurance, or similar insurance policies for the **Insured Entity** ever been cancelled or non-renewed? (NOT APPLICABLE IN MISSOURI) ❑ Yes ❑ No

General Information

4. The **Named Insured** has been in continuous operation since:

5. Does the **Insured Entity** currently have a tax-exempt status under the U.S. Internal Revenue Service Code? ❑ Yes ❑ No

   (a) If "Yes", indicate IRSC Section: ❑ 501 c 3 ❑ 501 c 6 ❑ other 501 c

   (b) If "No", provide an explanation:

   (c) Have there been or are there now pending, any disputes as to the **Insured Entity's** tax-exempt status? If "Yes" provide an explanation: ❑ Yes ❑ No

6. Describe the **Insured Entity's** nature of operations: _____

_____

_____

7. Provide the following financial information with respect to the **Insured Entity**: Period Ending: / /

Assets: $ _____ Net Assets:* $ _____ Annual Revenues: $ _____

*Net Assets equals Total Assets minus Total Liabilities

8. Does the **Insured Entity** have any **Subsidiaries**? ❑ Yes ❑ No

If "Yes", provide the following information on all **Subsidiaries** of the **Insured Entity**.

Subsidiary or Organization Name	Nature of Business	Not For Profit?	Total Assets	Is coverage requested for this entity under this **Policy**?
		❑ Yes, IRSC:_____ ❑ No	$	❑ Yes ❑ No
		❑ Yes, IRSC:_____ ❑ No	$	❑ Yes ❑ No

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES OR RELATED ORGANIZATIONS IN QUESTION 8 UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED.

9. Is the **Insured Entity** currently in bankruptcy? ❑ Yes ❑ No

10. Within the next 12 months:

(a) is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code? ❑ Yes ❑ No

(b) does the **Insured Entity** anticipate any plant, facility, branch or office closings, or layoffs? ❑ Yes ❑ No

(c) does the **Insured Entity** anticipate any consolidation, divestment, acquisition, tender offer or merger? ❑ Yes ❑ No

11. Within the last 12 months has there been any change (resignations, departures, retirements, etc.) in the position of the Chairman of the Board, President, Chief Executive Officer, Chief Financial Officer or Managing Partner (or equivalent position) that fall outside the scope of annual elections or bylaws? ❑ Yes ❑ No

IF "YES" TO ANY PART OF QUESTIONS 9, 10 AND 11, PROVIDE FULL DETAILS

_____

_____

Directors, Officers and Organization Liability Insurance Coverage Section

12. Does the **Insured Entity**:

(a) provide any professional services including, but not limited to, legal counseling, medical care, peer review, standards setting, standards certification and/or credentialing activities to others? ❑ Yes ❑ No

(b) promote, sponsor or provide any form of insurance to its members or non-members? ❑ Yes ❑ No

(c) have a membership in any nonprofit or professional associations? ❑ Yes ❑ No

If "Yes", provide association names: _____

Employment Practices Liability Insurance Coverage Section (Complete this section if this coverage is desired)

13. Number of **Employees**:

	Full Time	Part Time	Leased	Seasonal and/or Temporary	Volunteers and/or Interns	Independent Contractors	Annual Turnover Rate
Current Year:							
Last Year:							

14. Does the **Insured Entity** currently employ a full time Human Resources professional? ❑ Yes ❑ No

15. Indicate which formal written policies and procedures have been implemented. If "None", check box ☐ None

☐ Employee Handbook / Manual
☐ Social Media Policy
☐ I-9 Verification

Employers with more than 50 Employees
☐ Family Medical Leave Act

California Employers Only
☐ California Family Rights Act

Fiduciary Liability Insurance Coverage Section (Complete this section if this coverage is desired)

16. Provide the following information regarding each employee welfare benefit plan, employee pension benefit plan or pension plan, as defined by **ERISA**, (hereinafter referred to as **Employee Benefit Plans**) which the **Insured Entity** maintains or to which it contributes.

Name of Plan	Type of Plan*	Name of Plan Sponsor	Number of Plan Participants	Fair Market Value of Plan Assets
				$
				$
				$

*Type of Plan: (DB)=Defined Benefit; (DC)=Defined Contribution; (ESOP)=Employee Stock Ownership Plan; (WB)=Health & Welfare Benefit; (MEP)=Multi Employer Plan or Multiple Employer Plan; (O)=Other

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR EMPLOYEE BENEFIT PLAN(S) IN QUESTION 16 FOR WHICH THE ABOVE INFORMATION IS INCOMPLETE OR NOT PROVIDED.

17. Has any **Employee Benefit Plan** loaned or pledged any **Employee Benefit Plan** assets to any party-in-interest (including the **Inured Entity**)? If "Yes", provide full details in the additional space for responses. ☐ Yes ☐ No

18. Are there any overdue employer contributions for any plan, or has any plan requested or contemplated filing a request for a waiver of contributions? If "Yes", provide plan name and amount of overdue contributions the additional space for responses. ☐ Yes ☐ No

19. Within the last 3 years, has there been, or is there currently under consideration, any restructuring, termination or other similar transaction of any **Employee Benefit Plan**? If "Yes", provide the following details of the transaction in the additional space for responses: whether assets have been fully distributed; date or expected date of any transfer of employees or **Employee Benefit Plans**; copies of any materials relating to the transaction that were distributed to employees or filed with government agencies. ☐ Yes ☐ No

20. If any of the following questions are answered "No", provide full details in the additional space for responses.

(a) Are all **Employee Benefit Plans** compliant with the Health Insurance Portability and Accountability Act ("HIPAA")? ☐ Yes ☐ No

(b) Does the plan sponsor comply with the summary plan description requirements under **ERISA** for all **Employee Benefit Plans**? ☐ Yes ☐ No

(c) Are all employee pension benefit plan or pension plan assets managed by a third party investment manager? ☐ Yes ☐ No

(d) Is the "fair market value" of all employee pension benefit plan or pension plan assets calculated at least annually? ☐ Yes ☐ No

ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU ARE APPLYING FOR THIS COVERAGE WITH CAROLINA CASUALTY INSURANCE COMPANY FOR THE VERY FIRST TIME. IF YOU ARE CURRENTLY INSURED WITH CAROLINA CASUALTY INSURANCE COMPANY, PLEASE DO NOT RESPOND TO THE QUESTIONS BELOW.

Loss History Information

21. During the last 5 years, has any **Insured**, including any **Subsidiary**, received any written demands for monetary or non-monetary relief, been involved in, or had any knowledge of any civil or criminal action, administrative or arbitration, regulatory investigation or proceeding, including both domestic or foreign equivalents, involving:

(a) any current or former employee or third party alleging discrimination, harassment, wrongful discharge and/or any wrongful employment act? ☐ Yes ☐ No

(b) the Equal Employment Opportunity Commission or any similar state or local agency? ☐ Yes ☐ No

(c) the U.S. Department of Labor or any similar state or local agency, alleging violations of any wage and hour law, including but not limited to, the Fair Labor Standards Act? ❑ Yes ❑ No

(d) any government agency such as the Labor Department or fair employment agency? ❑ Yes ❑ No

(e) the U.S. Immigration and Customs Enforcement Agency? ❑ Yes ❑ No

(f) the National Labor Relations Board? ❑ Yes ❑ No

(g) any investigation by the Internal Revenue Service, Department of Labor, Pension Benefit Guarantee Corporation, or any other local, state or federal agency? ❑ Yes ❑ No

(h) any intellectual property disputes, including Copyright, Patent, or Trademark Laws? ❑ Yes ❑ No

(i) any Anti-Trust or Fair Trade Law? ❑ Yes ❑ No

(j) the Foreign Corrupt Practices Act? ❑ Yes ❑ No

(k) the Office of Federal Contract Compliance Programs? ❑ Yes ❑ No

(l) any current or former employee or any third party alleging breach of any oral or written contract? ❑ Yes ❑ No

(m) any investigation by the IRS, Department of Labor ("DOL"), Pension Benefit Guarantee Corporation ("PBGC"), or any other state or federal agency of any **Employee Benefit Plan** or any current or former fiduciary of such **Employee Benefit Plan**? If "Yes", provide details in the additional space for responses. ❑ Yes ❑ No

22. During the last 5 years, has any **Insured**, including any **Subsidiary** been involved in any lawsuit not disclosed above? ❑ Yes ❑ No

Prior Knowledge Information

23. Is any **Insured** aware of any fact, circumstance or situation involving any **Insureds** that might reasonably be expected to result in a **Claim** as defined in each **Coverage Section** applied for? ❑ Yes ❑ No

IF "YES" TO QUESTIONS 21, 22 OR 23, COMPLETE THE CLAIM / INCIDENT SUPPLEMENT.

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTIONS 21, 22 OR 23 OF THIS SECTION.

Please Read Carefully

The undersigned, acting on behalf of all **Insureds**, declare that the representations and statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each and every **Insured** proposed for this insurance to facilitate the proper and accurate completion of this **Application**.

The undersigned agree that the statements in the **Application** are their representations, that they are material to the acceptance of the risk and the hazard assumed by the **Insurer**.

The undersigned further agree that the **Application** and any material submitted herewith shall be maintained on file with the **Insurer** and shall be deemed to be attached hereto as if physically attached to the **Policy**.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this **Application** and the **Policy** inception date, which would render this **Application** inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any **Policy**, if issued, will be in reliance upon the truth of such representations; however, with respect to such statements and representations, no knowledge or information possessed by any **Insureds** shall be imputed to any other **Insureds**. If any person or persons knew as of the **Policy** inception date that such declarations and statements contained in the **Application** were untrue, inaccurate or incomplete, then this **Policy** shall not apply to that person or persons;
- however, if the signer of the **Application** knew as of the **Policy** inception date that such representations and statements contained in the **Application(s)** were untrue, inaccurate or incomplete, then this **Policy** shall not apply to that person or persons and the **Insured Entity**;

- this **Application** has been completed as respects the entire **Insured Entity**;
- the signing of this **Application** does not bind the undersigned to purchase the insurance.

Dated	(Signature)
Title	(Print Name)

This **Application** must be signed by a Director, Officer or General Manager of the **Named Insured**.

This Carolina Casualty Insurance Company Application, including any material submitted herewith, shall be held in strictest confidence.

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

Additional Space for Responses

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, RHODE ISLAND, WEST VIRGINIA 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.

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 FOR INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

KANSAS APPLICANTS: 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, COMMITS A FRAUDULENT INSURANCE ACT AND MAY BE SUBJECT TO CRIMINAL AND/OR CIVIL FINES OR PENALTIES.

KENTUCKY, PENNSYLVANIA 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.

MAINE, TENNESSEE, VIRGINIA, 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.

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.

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.

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.

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.

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.

OREGON 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 MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES.

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.

Carolina Casualty Insurance Company

NonProfit ExecShield® Claim / Incident Supplement

THIS APPLICATION IS FOR A CLAIMS MADE POLICY. THIS POLICY PROVIDES COVERAGE ON A CLAIMS MADE AND REPORTED BASIS. SUBJECT TO ITS TERMS, THIS POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS AND REPORTED TO THE INSURER DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD THAT MAY APPLY.

Whenever printed in this Claims Supplement Form, the terms in boldface type shall have the same meanings as indicated in the **Policy**. This Claim/Incident Supplemental Form is to be completed with respect to the entire **Insured Entity**. **Insured Entity** as used herein is defined to include the **Named Insured** and any **Subsidiaries**.

Name of **Named Insured**

INSTRUCTIONS
COMPLETE ONE FORM FOR EACH CLAIM, SUIT, OR CIRCUMSTANCE DURING THE LAST 5 YEARS. IF SPACE IS INSUFFICIENT TO ANSWER ANY QUESTIONS FULLY, PROVIDE SEPARATE ATTACHMENTS.

Producer Information

Submitted by (Agency Name) _____ Dated _____

Agent's Name (Individual's Name) _____ Agent's License Number _____

Claim Information

1. Full name and title or position of individual(s) involved in the **Claim**, suit, or circumstance which could give rise to a **Claim**:
   Full name(s) of Claimant (Plaintiff):
   (a) _____ Position / Title: _____
   (b) _____ Position / Title: _____
   Full name(s) of Defendant:
   (a) _____ Position / Title: _____
   (b) _____ Position / Title: _____
2. Date alleged Claim, suit, or circumstance occurred: _____
3. Date Claim made against an Insured: _____
4. Has this Claim, suit, or circumstance been reported to any insurance carrier? ☐ Yes ☐ No
   If "Yes", date reported to insurance company: _____
5. To which insurance company did you report this **Claim**, suit, or circumstance? _____
6. Current status of **Claim**, suit, or circumstance (circle one): Closed Open In Suit Potential
7. If **Claim**, suit, or circumstance is Closed, provide the following:
   Total damages paid: $ _____ Total expenses paid (including deductible): $ _____

(TOTAL DAMAGES PAID AND TOTAL EXPENSES PAID INCLUDING ANY DEDUCTIBLE AMOUNTS MUST BE PROVIDED.)

8. If **Claim**, suit, or circumstance is Open, In Suit, or Potential, provide the following:
   Total damages demanded: $ _____ Total expenses paid to date: $ _____
9. (a) What specific causes of action are alleged in the **Claim**, suit, or circumstance? (Sexual Harassment, Discrimination, Wrongful Termination, etc.):

(b) Description of events that gave rise to the **Claim**, suit, or circumstance (attach a copy of the formal complaint, charges, etc., if applicable).

(c) How did the **Insured Entity's** respond to the allegations in the **Claim**, suit, or circumstance?

(d) Describe how the **Claim**, suit, or circumstance was investigated and by whom:

(e) What policies and/or procedures have been implemented or revised to prevent a recurrence or similar **Claim**, suit, or circumstance?

Please Read Carefully

I understand that the information submitted herein becomes a part of the **Insured Entity's** Nonprofit Management Liability Insurance Application, and is subject to the same representations and conditions.

Dated	(Signature)
Title	(Print Name)

This **Application** must be signed by a Director, Officer or General Manager of the **Named Insured**.
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