



**NOTICE:** ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO "CLAIMS" FIRST MADE OR DEEMED MADE AGAINST "INSUREDS" DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED BY THE AMOUNTS INCURRED AS "DEFENSE EXPENSES", AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY "CLAIM" UNLESS DUTY-TO-DEFEND COVERAGE HAS BEEN SPECIFICALLY PROVIDED HEREIN.

AGENCY	CODE	AGENT NAME / LICENSE NUMBER
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The term "**Applicant**" means the first named insured organization and all other corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

**Please submit the following documents and indicate below which are included in conjunction with this application. Note that the Company may elect to obtain some of this information from public sources, including the internet.**

**REQUIRED GENERAL ATTACHMENTS**

- Most recent CPA audited financial statements including notes and schedules.
- Most recent CPA letter to management and management's response.
- Interim financial statements, if audited financial statements are six (6) months or older.
- Loss runs for the past five (5) years and a status report of any litigation filed within the last five (5) years by or against any person(s) or **Applicant** proposed for this insurance including amount of any settlements or judgments, costs of defense and any corrective procedures implemented by the Applicant.

**REQUIRED D&O ATTACHMENTS**

- A listing of the Board of Directors, Board of Managers or the Board of Trustees, as applicable, with employers and occupations of each, as well as other boards on which such directors, managers or trustees serve.
- If applicable for any **Applicant**, any private placement memorandum(s) or any other documents filed with the Securities Exchange Commission during the last three (3) years.
- Copy of the **Applicant's** bylaws, health care/medical staff by-laws, and other operating agreements.
- Current organizational chart of the first named insured organization, listing each subsidiary, controlled non-profit organization and joint venture, including the ownership percentage and tax status of each.
- A copy of the most recent actuarial study, if any **Applicant's** health care/medical professional liability exposure is self-insured or insured by means of a trust, captive, risk sharing arrangement or pool.

**REQUIRED EPL ATTACHMENTS**

- Directors, Officers & Trustees required attachments.
- Employee Handbook, including current amendments.
- Most recent EEO-1 report, if **Applicant** has 1,000 or more employees.

## A. COMMON SECTION

### GENERAL INFORMATION

**Applicant Information:**

Name of first named insured organization: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Website address: \_\_\_\_\_ Date established or incorporated: \_\_\_\_\_

Tax Status of the first named insured organization: .....  Non-Profit  For-Profit

**Entity Type:**

<input type="checkbox"/> 501(c)(3)	<input type="checkbox"/> S Corporation	<input type="checkbox"/> General Partnership (GP)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> 501( ) ( )	<input type="checkbox"/> C Corporation	<input type="checkbox"/> Limited Partnership (LP)	_____
	<input type="checkbox"/> Limited Liability Company (LLC)	<input type="checkbox"/> Limited Liability Partnership (LLP)	_____

### CONTACT INFORMATION FOR AUTHORIZED REPRESENTATIVE(S)

**Risk Manager or authorized representative(s) designated to receive any and all notices concerning this insurance.**

Designated Contact: \_\_\_\_\_ Contact Email: \_\_\_\_\_  
 Title: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

*Complete address if different than provided on this Application under General Information.*

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

### NATURE OF BUSINESS (CHECK ALL THAT MAY APPLY)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Adult day Care                  | <input type="checkbox"/> HMO, PPO, Health Plan              | <input type="checkbox"/> Non-Profit Health Care Foundation          |
| <input type="checkbox"/> Affiliate Hospital System       | <input type="checkbox"/> Home Health Care                   | <input type="checkbox"/> Physician Group                            |
| <input type="checkbox"/> Ambulatory Surgery Center       | <input type="checkbox"/> Hospice Care                       | <input type="checkbox"/> Physician Hospital Organization (PHO)      |
| <input type="checkbox"/> Assisted Living Facility / CCRC | <input type="checkbox"/> Hospital                           | <input type="checkbox"/> Psychiatric Hospital                       |
| <input type="checkbox"/> Behavioral & Mental Health      | <input type="checkbox"/> Integrated Delivery System         | <input type="checkbox"/> Rehabilitation Facility                    |
| <input type="checkbox"/> Blood / Organ Collection Center | <input type="checkbox"/> IPA, PPO, MSO                      | <input type="checkbox"/> Respite Care                               |
| <input type="checkbox"/> Clinical Research Facility      | <input type="checkbox"/> Laboratory                         | <input type="checkbox"/> Skilled Nursing Facility / Retirement Home |
| <input type="checkbox"/> Dependency Rehab                | <input type="checkbox"/> Management Company System          | <input type="checkbox"/> Social Service                             |
| <input type="checkbox"/> Eye Care Center                 | <input type="checkbox"/> Network Provider                   | <input type="checkbox"/> Surgical Center                            |
| <input type="checkbox"/> Faculty Practice Group          | <input type="checkbox"/> Non-Profit Clinic                  | <input type="checkbox"/> Trade Association                          |
| <input type="checkbox"/> Health System                   | <input type="checkbox"/> Non-Profit Health Care Association | <input type="checkbox"/> Other: _____                               |

*If necessary, please attach full details.*

**SUBSIDIARY AND CONTROLLED NON-PROFIT ORGANIZATION INFORMATION**

Subsidiary and controlled non-profit organization information (Include 50% owned joint ventures under management control):

Name	% Owned	Year Started	Description of Operations	Tax Status*	Entity Type**

\*Tax Status: FP = For Profit or NP = Non-Profit

\*\*Entity Types, for example: 501(c)(3); S Corporation, General Partnership (GP); Limited Partnership (LP); Limited Liability Partnership (LLP); Limited Liability Company (LLC)

*If there are additional subsidiaries or controlled organizations, please attach a detailed listing or organizational chart.*

**CURRENT INSURANCE INFORMATION**

Coverage	Carrier	Limit	Retention	Premium	Policy Period
Directors, Officers & Trustees (D&O)		\$	\$	\$	
Employment Practices Liability (EPL)		\$	\$	\$	
Excess D&O and/or EPL		\$	\$	\$	
Health care / Medical Professional Liability		\$	\$	\$	
General Liability		\$	\$	\$	
Fiduciary Liability		\$	\$	\$	
Crime		\$	\$	\$	
Kidnap & Ransom		\$	\$	\$	
Identity Fraud Expense Reimbursement		\$	\$	\$	

- Have any of the coverages above been cancelled or non-renewed during the last three years? (not applicable in Missouri) *If "Yes", please attach full details.* .....  Yes  No
- Are any of the **Applicant's** health care/medical professional liability or general liability coverages self-insured or insured by means of a self-insured trust, captive, risk sharing arrangement or pool?.....  Yes  No  
 If "Yes", regarding the **Applicant's** self-insurance program:
  - Is an annual independent actuarial exam performed?.....  Yes  No  
*If "Yes", please provide a copy.*
  - Is the program funded in accordance with annually determined actuarial requirements? .....  Yes  No  
*If "No", please attach full details.*
  - Does the program provide insurance to third parties? .....  Yes  No  
*If "Yes", please attach full details.*
- Does the **Applicant** have coverage for peer review and credentialing activities under any other insurance policy, self-insured trust, captive, risk sharing arrangement or pool? .....  Yes  No

## B. DIRECTORS, OFFICERS & TRUSTEES LIABILITY COVERAGE

**NOTICE:** The section below only pertains to Directors, Officers & Trustees Liability Coverage. If Employment Practices Liability Coverage is desired, please complete Section C. of this application.

### SECURITYHOLDER INFORMATION

1. Total Shares	Common	Preferred	Other
Authorized			
Outstanding (stock held by shareholders)			
Voting Shares Outstanding			
Voting Shares Owned by Directors and Officers (direct & beneficial)			
Number of Voting Shareholders			

*If there are multiple classes of stock, please attach full details.*

2. Please list all securityholders that own more than 5% of any class of security.

Securityholder	Class of Security	% Owned	Director, Trustee or Officer?
		%	<input type="checkbox"/> Yes <input type="checkbox"/> No
		%	<input type="checkbox"/> Yes <input type="checkbox"/> No
		%	<input type="checkbox"/> Yes <input type="checkbox"/> No
		%	<input type="checkbox"/> Yes <input type="checkbox"/> No
		%	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If there are more securityholders, please attach full details.*

3. Does any **Applicant** have an Employee Stock Ownership Plan (ESOP) or any stock option program? .....  Yes  No

*If "Yes", please provide the most recent stock evaluation report and program documentation.*

### BUSINESS OPERATIONS

1. Is any **Applicant** presently JCAHO accredited? .....  N/A  Yes  No

If "Yes", please provide the Names of the Organizations	Date	Last Overall Score

2. During the last 3 years, has any regulatory or accrediting body denied, suspended, revoked or granted, or subjected to contingency or recommendation, any license, certification or accreditation of any operation, department or facility of any **Applicant**? *If "Yes", please attach full details.*.....  N/A  Yes  No

3. Does the **Applicant** perform peer review or credentialing activities for its health care staff?.....  Yes  No

(a) Does the **Applicant** have formal written policies and procedures in effect that address peer review, credentialing, re-credentialing and decisions that could adversely affect health care staff membership, privileges or licensing? .....  Yes  No

If "Yes", (i) Do written policies and procedures meet NCQA or JCAHO standards or applicable law?.....  Yes  No

(ii) Are written policies and procedures provided to all members of the health care staff? .....  Yes  No

(b) Is legal counsel consulted before any recommendation or decision is finalized that could adversely affect health care staff membership, privileges or licensing? .....  Yes  No

(c) During the last five (5) years has any **Applicant** been subject to any legal recourse associated with restriction or suspension of the license or privileges of any member of the health care staff? .....  Yes  No

*If "Yes", please attach full details.*

4. Does any **Applicant** render any standard setting, accrediting, peer review, credentialing, licensing or similar services to any third party? *If "Yes", please attach full details.* .....  Yes  No
5. Does any **Applicant** provide any non-clinical management or administrative services to any third party under any contract or agreement? *If "Yes", please attach full details.* .....  Yes  No
6. Is any **Applicant** managed or administered by any third party under contract or agreement?  
*If "Yes", please attach full details.* .....  Yes  No
7. Have any **Applicants** had any changes in the Board of Directors, Board of Managers, Board of Trustees or executive officers within the past two (2) years for reasons other than completion of their term or retirement?  
*If "Yes", please attach full details.* .....  Yes  No
8. Does the **Applicant** have a formal committee of independent Directors, Managers or Trustees that reviews executive compensation? .....  Yes  No
9. The **Applicant's** Directors, managing members or Trustees assume the position by?  
 Membership Vote       Appointed  
by: \_\_\_\_\_  Other: \_\_\_\_\_
10. Has any **Applicant** undergone during the last twelve (12) months or does any **Applicant** plan to undergo during the next twelve (12) months any of the following
  - (a) actual creation or proposed merger, acquisition, or divestiture? .....  Yes  No
  - (b) creation of a new subsidiary, a division or area of business? .....  Yes  No
  - (c) issuance of debt, a tax exempt bond offering, a public offering or a private placement of securities? .....  Yes  No
  - (d) reorganization or arrangement with creditors under federal or state law? .....  Yes  No
  - (e) closure or consolidations of any branch, location, facility, office, or subsidiary? .....  Yes  No*If "Yes" to any of 11(a) – (e) above, please attach full details.*
11. Does the **Applicant's** market share (whether hospital beds, providers, health care services provided or membership in a network) exceed 25% within any of its geographical service areas?  
*If "Yes", please attach full details.* .....  Yes  No
12. Does the **Applicant** seek outside legal advice on matters of non-compete clauses, exclusive contracts or preferred pricing contracts? .....  Yes  No

**COMPLIANCE POLICIES AND PROCEDURES**

1. Does the **Applicant**:
  - (a) have a formal written regulatory compliance policies and procedures (*for example, the federal False Claims Act and Health Insurance Portability and Accountability Act (HIPAA)*) addressing the responsibilities of the **Applicant**, its business partners, vendors and employees? .....  Yes  No  

*If "Yes":*    Date Implemented: \_\_\_\_\_      Date Last Revised: \_\_\_\_\_
  - (b) implement regular compliance education and training? .....  Yes  No
  - (c) utilize audits or other evaluation techniques to monitor compliance? .....  Yes  No
  - (d) utilize outside counsel to provide an opinion as to whether there could be a violation of law? .....  Yes  No
2. Has any **Applicant**:
  - (a) been subject to any regulatory investigation or indictment involving patient billing, business referral(s) or any anti-kick back law? .....  Yes  No
  - (b) been subject to any type of federal or state mandate or regulatory compliance oversight (*for example, a corporate integrity agreement*)? .....  Yes  No
  - (c) been subject to any type of regulatory monetary settlement, fine or penalty? .....  Yes  No*If "Yes" to any of 2(a)- (c) above, please attach full details.*
3. Does the **Applicant** have a formal written conflict of interest policy? .....  Yes  No
4. Does the **Applicant** have a formal charity care policy that meets or exceeds applicable minimum state and federal requirements? .....  Yes  No

**DIRECTORS, OFFICERS AND TRUSTEES LOSS INFORMATION**

1. Has there been during the past five years, or are there now pending, any securities claims, criminal actions, administrative or regulatory proceedings, charges, hearings, demands or lawsuits including shareholder, creditor, antitrust, fair trade law, copyright or patent litigation, against any **Applicant**, or any person proposed for this insurance, whether or not such claim or action would be covered under the Health Care Organization Directors, Officers and Trustees Liability Coverage? .....  Yes  No

*If "Yes", please provide the date, a brief description, and the damages sought or settlement paid, of such a claim, and the current status if pending.*

2. During the past five years, has any claim, or notice of circumstances that could reasonably give rise to a claim, been reported to any previous or existing insurer providing coverage for directors, officers and trustees liability, or management liability, including any coverage for the entity? .....  Yes  No

*If "Yes", please attach full details.*

**To the extent that any matter required to be disclosed in response to questions 1 or 2 above constitutes a "Claim" as defined by the Policy, such matter was made prior to the policy period requested hereunder and therefore would be excluded from coverage.**

3. Does the **Applicant**, or any person proposed for this insurance have any knowledge or information of any fact, circumstance or situation related to the Health Care Organization Directors, Officers and Trustees Liability Coverage that could reasonably give rise to a claim against them? .....  Yes  No

*If "Yes", please attach full details.*

**Without prejudice to any other rights and remedies of the Company, any claim arising from any facts or circumstances required to be disclosed in question 3 above is excluded from the proposed insurance.**

**C. EMPLOYMENT PRACTICES LIABILITY COVERAGE**

**NOTICE:** Please complete the section below if Employment Practices Liability coverage is desired.

1. Please provide the total number of employees for all **Applicants** for each category below:

Full Time Employees	Part Time Employees	Leased Employees	% Union Employees	Total Employees	Employed Physicians	Independent Contractors

**Provide EEO-1 report only if an Applicant has 1,000 or more employees.**

2. Turnover of total full time employees for all <b>Applicants</b> for each of the last three years (in number of employees):	20__	20__	20__
Voluntary Terminations of Full Time Employees			
Involuntary Terminations of Full Time Employees			
Layoffs of Full Time Employees			

**HUMAN RESOURCES**

Does the **Applicant**:

1. Have a centralized Human Resources (HR) department? .....  Yes  No

Number of dedicated HR employees: \_\_\_\_\_

Does the HR department:

(a) provide formal employment practices liability training, including sexual harassment training, to the **Applicant's** managers and supervisors? .....  Yes  No

(b) follow a formal manual when implementing HR policies and procedures? .....  Yes  No

If "Yes", date last updated: \_\_\_\_\_

(c) consult with legal counsel prior to every termination, lay off or staff reduction? .....  Yes  No

2. Utilize an employment application? .....  Yes  No

Does the employment application contain:

(a) "Employment at Will" language? .....  Yes  No

(b) an "Equal Employment Opportunity" statement? .....  Yes  No

3. Have an Employee Handbook? .....  Yes  No  
 If "Yes", date last updated: \_\_\_\_\_
- (a) Is it distributed to all employees? .....  Yes  No  
 (b) Is it intranet based? .....  Yes  No
4. Use any test to screen applicants or employees? .....  Yes  No  
*If "Yes", please attach full details.*
5. Please indicate whether the **Applicant** has formal written policies and procedures related to the following and indicate whether employees sign and acknowledge receipt:

	<b>Written Policy or Procedure</b>	<b>Sign &amp; Acknowledge Receipt</b>
Employment at Will .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Equal Employment Opportunity .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
New Employee Orientation .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Annual Written Performance Evaluation .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Zero Tolerance for Sexual Harassment .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discrimination and Harassment .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical Leave Act .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disabled Employees and Accommodations .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grievance Procedures .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Discipline .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anti-Retaliation (including employee whistleblower protection) .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee conduct when dealing with the general public .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Consumer or other third party complaints .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Does the **Applicant** perform criminal background checks on all employment applicants considered for hire? .....  Yes  No
7. Have the policies and procedures in questions 1-6 above been reviewed by legal counsel within the last 24 months? .....  Yes  No
8. Are the policies and procedures in questions 1-6 above (consistent or centralized) throughout all of the **Applicants**? .....  Yes  No
9. Has any **Applicant** undergone within the last 12 months or does any **Applicant** plan to undergo, during the next 12 months any lay-offs, downsizing or any other reduction in work force? .....  Yes  No  
*If "Yes", please attach full details.*

**EMPLOYMENT PRACTICES LOSS INFORMATION**

1. Has there been during the past five years, or is there now pending, any employment-related claims, administrative proceedings, charges, hearings, demands or lawsuits against the **Applicant** or any person proposed for this insurance whether or not insured, including claims involving employees, temporary, leased employees or independent contractors? .....  Yes  No  
*If "Yes", please provide the date, a brief description, and the damages sought or settlement paid, of such claim, and the current status if pending.*
2. During the past five years, has any claim, or notice of circumstances that could reasonably give rise to a claim, been reported to any previous or existing insurer providing coverage for employment practices liability? .....  Yes  No  
*If "Yes", please attach full details.*

**To the extent that any matter required to be disclosed in response to questions 1 or 2 above constitutes a "Claim" as defined by the Policy, such matter was made prior to the policy period requested hereunder and therefore would be excluded from coverage.**

3. Does any **Applicant**, or any person proposed for this insurance have any knowledge or information of any fact, circumstance or situation involving any law related to employment that could reasonably give rise to a claim against them? .....  Yes  No  
*If "Yes", please attach full details.*

**Without prejudice to any other rights and remedies of the Company, any claim arising from any facts or circumstances required to be disclosed in question 3 above is excluded from the proposed insurance.**

**Attention: Insureds in AR, CO, DC, KY, LA, NJ, NM, NY, and OH**

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.)

**Attention: Insureds in FL**

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 felony of the 3<sup>rd</sup> degree, and may also be subject to a civil penalty.

**Attention: Insureds in ME, TN, VA, and WA**

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.

**Attention: Insureds in 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.

**Attention: Insureds in PR**

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**D. SIGNATURE**

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 TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY 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, IN ALL STATES OTHER THAN NC 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 THEREWITH, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

**E. REQUIRED COMPLETION – PLEASE READ AND SIGN**

First Named Insured

Signature of Chairman, President, CEO or Administrator (required)	Date
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Title

*G.J. Sullivan Co. Excess and Surplus Lines Brokers, on behalf of the Company, is hereby authorized to make any investigation and inquiry in connection with this application as they may deem necessary.*





## **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](http://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.