



Protective
Insurance Company

Flood **NON PROFIT MANAGEMENT LIABILITY**
INSURANCE APPLICATION - FLORIDA

CLAIMS MADE WARNING FOR APPLICATION: This Proposal Form is for a Claims Made and Reported Policy, relating to claims made against the Insureds during the Policy Period or any Extended Reporting Period that may apply.

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the **Policy**. This Proposal 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**

I. Applicant's General Information

1. Name of **Named Insured**: _____
2. Street Address Suite _____
3. City/ County/ State /Zip Code: _____
4. Website Address: _____

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

1. Contact Name/Title: _____
2. E-mail Address /Telephone Number : _____

Producer Information:

1. Submitted by (Agency Name): _____
2. Agent's Name (Individual's Name): _____
3. Agent's License Number: _____

II. Coverage Desired

1. Directors, Officers and Organization Liability: Yes No Limit Requested: \$ _____
2. Employment Practices Liability: Yes No Limit Requested: \$ _____
3. Fiduciary Liability: Yes No Limit Requested: \$ _____
4. Indicate the type of limit requested:
 - Policy Aggregate Limit of Liability for all Insuring Agreements, or
 - Separate Aggregate Limit of Liability for each Insuring Agreement

III. Current Insurance Information

1. Provide the following information regarding the most recent insurance policies.
(If no current coverage please insert "N/A")

Coverage	Insurance Company	Expiration Date	Limit of Liability	Retention	Premium
Directors & Officers Liability					
Employment Practices Liability					
Fiduciary Liability					

2. Within the last 3 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?
(If "yes" please complete the Claim Supplemental Application) Yes No

3. Within the last 3 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?
 (If "yes" please attached details) Yes No

IV. Prior Knowledge Information

1. Is any **Insured** aware of any fact, circumstance or situation involving any **Insureds** that might reasonably be expected to result in a Claim? Yes No

If "YES" to Question III. 1., Please provide the following information for each allegation even if the matter has been settled or otherwise resolved:

- a) Date Claim first made
- b) Claimant's Name
- c) Allegation
- d) Current Status
- e) Demand Amount
- f) Settlement (Indemnity) or Reserve Amount
- g) Attorney's fees

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 QUESTION III. 1.

V. Management Liability and Non Profit Organizational Liability

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

If "Yes", under which IRSC Section? _____
 If "No", provide an explanation: _____

2. Have there been or are there now pending, any disputes as to the **Insured Entity's** tax-exempt status? Yes No

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

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

5. Does the **Insured Entity** own or hold any patents? Yes No
 "Yes", how many? _____

6. Does the **Insured Entity**:
- a) provide any professional services including, but not limited to, legal counseling, medical care, peer review and credentialing activities to others? Yes No
 - b) promote, sponsor or provide any form of insurance to its members or non-members? Yes No
 - c) transact electronic commerce on behalf of itself, members or third parties? Yes No

- d) have a membership in any nonprofit or professional associations? Yes No
If "Yes", provide association names _____

7. Provide the following information on all **Subsidiaries** or related organizations of the **Insured Entity**. If necessary, please add details by attachment. If "None", so state. None

- a) **Subsidiary** or Organization Name; _____
b) Nature of Business: _____
c) Not For Profit? Yes, IRSC: _____ No
d) Total Assets: \$ _____
e) Is coverage requested for this entity under this **Policy**? Yes No

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES OR RELATED ORGANIZATIONS IN QUESTION 7. UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED.

8. Provide the following financial information with respect to the **Insured Entity**: Period Ending: ___ / ___ / ___
Assets (000): \$ _____ Fund Balance (000): \$ _____ Annual Revenues (000): \$ _____

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

10. Within the next 12 months, is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code? Yes No

11. Within the last 3 years, have there been resignations, departures, retirements, or terminations in the position of the Chairperson of the Board of Directors, President, Chief Executive Officer, Executive Director, or Chief Financial Officer? Yes No
If "Yes", provide the following details by attachment: Name of individual; date of change; and reason for change.

12. During the last 5 years, has the **Insured Entity** or any of the **Insured Persons** 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 proceeding, including both domestic or foreign equivalents, involving:

a) any intellectual property disputes, including Copyright, Patent, or Trademark Laws? Yes No
b) any alleged violation of any Federal or State Security Law or Regulation? Yes No
c) any alleged violation of any Federal or State Anti-Trust or Fair Trade Law? Yes No
d) any other allegations of violations of federal, state or local statute, regulation, ordinance or common law that would otherwise be within the scope of this proposed insurance? Yes No

IF "YES" TO ANY PART OF QUESTION 12, PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

- a) Date Claim first made
b) Claimant's Name
c) Allegation
d) Current Status
e) Demand Amount
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VI. Employment Practices Liability (Complete this section only if this coverage is desired)

1. Number of **Employees**: (current year & previous year)

Year	Full Time	Part Time	Leased	Seasonal and/or Temporary	Volunteers and/or Interns	Independent Contractors	Annual Turnover Percentage

2. Indicate which formal written policies and procedures have been implemented. If "None", so state. None

- Employee Handbook / Manual
- Anti-Harassment Policy, including Employers with more than 50 Employees
- Anti-Discrimination Policy – Sexual Harassment
- Family Medical Leave Act
- Equal Employment Opportunity (EEO) Policy
- Adherence to Employment "at- will" relationship with all **Employees**
- California Family Rights Act (California Employers Only)

3. During the last 5 years, has any **Insured** known of, or been involved in any lawsuit, charges, inquiries, investigations, grievances or other administrative hearings or proceedings before any of the following agencies and/or in any of the following forums, including both domestic or foreign equivalents?

- a) National Labor Relations Board? Yes No
- b) Equal Employment Opportunity Commission? Yes No
- c) Office of Federal Contract Compliance Programs? Yes No
- d) U.S. Department of Labor? Yes No
- e) Any state or local government agency such as the Labor Department or fair employment agency? Yes No
- f) U.S. District or state court? Yes No

4. During the last 5 years, has any current or former **Employee** or third party made any Claim, or otherwise alleged discrimination, harassment, wrongful discharge and/or **Wrongful Acts** against any **Insured**? Yes No

A Claim is not limited to the filing of a lawsuit or complaint with the Equal Employment Opportunity Commission or similar state or local agency. A Claim may also include a written demand by any current or former **Employee** seeking relief in connection with an employment-related dispute or grievance.

IF "YES" TO ANY PART OF QUESTIONS 3., OR 4., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

- a) Date Claim first made
- b) Claimant's Name
- c) Allegation
- d) Current Status
- e) Demand Amount
- f) Settlement (Indemnity) or Reserve Amount
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VII. Fiduciary Liability (Complete this section only if this coverage is desired)

1. 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 *	Plan Sponsor	Number of 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 VI. 1. FOR WHICH THE ABOVE INFORMATION IS INCOMPLETE OR NOT PROVIDED.

2. Has any **Employee Benefit Plan** loaned or pledged any **Employee Benefit Plan** assets to any party-in-interest (including the **Insured Entity**)? If “Yes”, provide details by attachment. Yes No
3. 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 by attachment. Yes No
4. 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 details of the transaction by attachment. Yes No
5. If any of the following questions are answered “No”, provide details by attachment.
- 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) Do all employee pension benefit plans or pension plans have a written investment policy? Yes No
 - d) Are all employee pension benefit plan or pension plan assets managed by a third party investment manager? Yes No
 - e) Do the fiduciaries review the investment guidelines used by the investment managers at least annually? Yes No
 - f) Is the “fair market value” of all employee pension benefit plan or pension plan assets calculated at least annually? Yes No
5. During the last 5 years, has there been, or is there currently, 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 by attachment. Yes No

6. During the last 5 years, has any **Insured** been named as a party in any civil or criminal action, administrative, arbitration, regulatory or investigative proceeding, or received any other written demands for money or services that would be within the scope of this proposed insurance? Yes No

IF "YES" TO ANY PART OF QUESTION 25, PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

- a) Date Claim first made
- b) Claimant's Name
- c) Allegation
- d) Current Status
- e) Demand Amount
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VIII. Documents Required (The following information must be submitted with the completed Proposal Form

- The most recent year-end financial report (audited or reviewed)
- Biographies on each Board Member
- Copies (electronic preferred) of all policy and procedure manuals listed in Question 2 of the Employment Practice Section
- Copies of all audit reports of Form 5500's for each **Employee Benefit Plan**

Disclosure Warning

I understand that there is no coverage for punitive damages assessed directly against an insured under Florida law. However, I also understand that punitive damages that are not assessed directly against an insured, also known as "vicariously assessed punitive damages", are insurable under Florida law. Therefore, if any Policy is issued to the Applicant as a result of this Application and such Policy provides coverage for punitive damages, I understand and acknowledge that the coverage for Claims brought in the State of Florida is limited to "vicariously assessed punitive damages" and that there is no coverage for directly assessed punitive damages

Please Read Carefully

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

The undersigned agree that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and they are material and are the basis of the insurance contract. The undersigned further agree that the Proposal Form and any material submitted herewith shall be considered attached to and a part of the **Policy**. Any material submitted with the Proposal Form shall be maintained on file (either electronically or paper) with the **Insurer** and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the **Policy** inception date, which would render this Proposal Form 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; provided,

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 Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons. However, if the Chairperson of the Board of Directors, President, Chief Executive Officer, or Chief Financial Officer of the **Insured Entity** knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons and the **Insured Entity**; this Proposal Form has been completed as respects the entire **Insured Entity**; and the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

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

The signer of this application acknowledges and understands that the information provided in this Application is material to the Insurer's decision to provide the requested insurance and is relied on by the Insurer in providing such insurance. The signer of this application represents that the information provided in this Application is true and correct in all matters. The signer of this Application further represents that any changes in matters inquired about in this Application occurring prior to the effective date of coverage, which render the information provided herein untrue, incorrect or inaccurate in any way will be reported to the Insurer immediately in writing. The Insurer reserves the right to modify or withdraw any quote or binder issued if such changes are material to the insurability or premium charged, based on the Insurer's underwriting guides. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the Policy.

Fraud Warning

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.

Applicant's Signature: _____ Title: _____
Date: _____

Note: The Application must be signed by the President, Chairperson of the Board, Managing Member, or Executive Director

Agent's Signature: _____

Agent's Name (please print): _____

Agent's License Number: _____