



301 East 4th Street
Cincinnati, OH 45202

ExecProSM Fiduciary Renewal Proposal Form

THIS IS A CLAIMS MADE POLICY, READ IT CAREFULLY

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

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Number of: Full-Time Employees _____ Part-Time Employees _____ | | |
| 2. Does the Company make use of independent contractors or non-employee labor?
If yes , provide the number of such workers used in the last 12 months _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Employee Benefit Plan Information

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 3. Provide the name, type of plan, total asset value and/or the total annual contributions and number of participants (<i>active and retired or separated</i>) 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. (<i>Use form attached to this Proposal Form</i>). | | |
| 4. Has any plan covered under the current policy changed its name?
If yes , provide details: | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is coverage being sought for any additional or new plans?
If yes , please submit a full application for such plans with complete details. | <input type="checkbox"/> | <input type="checkbox"/> |

Plan Changes

Yes No

- | | | |
|--|--------------------------|--------------------------|
| 6. Have there been any changes in the use of or the identity of: | | |
| a. An investment management or consulting firm? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A certified public accounting firm? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. An outside law firm? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. An actuarial firm? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes , to any of (a) – (d), provide complete details: | | |

Plan Changes Continued

	Yes	No
7. In the past 12 months:		
a. Has any plan been consolidated or merged into any plan for which coverage is sought?	<input type="checkbox"/>	<input type="checkbox"/>
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? If yes, provide details.	<input type="checkbox"/>	<input type="checkbox"/>
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? 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.	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the Company or any Subsidiary expect any of the events set forth in question 6. above to occur in the next 12 months? If yes, provide details.	<input type="checkbox"/>	<input type="checkbox"/>

Compliance

	Yes	No
9. Does each plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), comply with the requirements of ERISA relating to eligibility, participation, vesting, funding and all other matters? If no, provide details.	<input type="checkbox"/>	<input type="checkbox"/>
10. At any time during the last 12 months has any plan had a funding deficiency?	<input type="checkbox"/>	<input type="checkbox"/>
11. At this time are there any delinquent contributions?	<input type="checkbox"/>	<input type="checkbox"/>
12. In the past 12 months, has there been any "reportable vent" as defined in ERISA with respect to any plan?	<input type="checkbox"/>	<input type="checkbox"/>
13. In the past 12 months, have there been any transactions involving plan assets involving anyone known to be a party-in-interest?	<input type="checkbox"/>	<input type="checkbox"/>
14. In the past 12 months, has any plan(s) invested in more than 10% of any corporation or partnership?	<input type="checkbox"/>	<input type="checkbox"/>
15. 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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes to any question 10. – 15. provide details.		

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, RHODE ISLAND AND 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.

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 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 _____

IOWA APPLICANTS:

Submitted by (*PRODUCER*) _____ Date _____

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 denial of insurance benefits.

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 OHIO APPLICANTS: Any person who, with the 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 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.

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 VIRGINIA AND WASHINGTON APPLICANTS: WARNING: 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 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 (\$5,000.00) and the stated value of the claim for each such violation.

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 Renewal 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 Renewal Proposal Form and the effective date of the Policy, which would render this Renewal Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the Insurer immediately. The signing of this Renewal 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 Renewal 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 Renewal 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 Renewal Proposal Form, any misstatement or omission in this Renewal 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 Renewal 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	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