IMPORTANT! This is a fillable pdf form and needs to be opened in the web browser in order to submit it online.

INSTRUCTIONS: Click here to open this document in a web browser.

Non-Profit Organization Executive Protection and Employment Practices Liability Insurance Policy

THIS IS A CLAIMS MADE POLICY. UPON TERMINATION OF COVERAGE FOR ANY REASON, A SIXTY (60) DAY AUTOMATIC DISCOVERY PERIOD WILL APPLY. FOR AN ADDITIONAL PREMIUM AN ADDITIONAL THREE YEAR DISCOVERY PERIOD CAN BE PURCHASED. EXCEPT TO SUCH EXTENT AS MAY BE PROVIDED HEREIN, THE COVERAGE PROVIDED BY THIS POLICY IS LIMITED TO LIABILITY FOR THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD, THE AUTOMATIC DISCOVERY PERIOD, ANY APPLICABLE DISCOVERY PERIOD OR ANY RENEWAL. HOWEVER, MORE THAN ONE CLAIM INVOLVING THE SAME WRONGFUL ACT OR REALTED WRONGFUL ACTS OF ONE OR MORE INSUREDS SHALL BE CONSIDERED A SINGLE CLAIM, AND ONLY ONE RETENTION SHALL BE APPLICABLE TO SUCH SINGLE CLAIM. ALL SUCH CLAIMS, CONSTITUTING A SINGLE CLAIM SHALL BE DEEMED TO HAVE BEEN MADE ON THE EARLIER OF THE FOLLOWING DATES (1) THE EARLIEST DATE ON WHICH ANY SUCH CLAIM WAS FIRST MADE; OR (2) THE EARLIEST DATE ON WHICH ANY SUCH WRONGFUL ACT OR RELATED WRONGFUL ACT WAS REPORTED UNDER THIS POLICY OR ANY OTHER POLICY PROVIDING SIMILAR COVERAGE.

THERE IS NO COVERGE FOR INCIDENTS THAT TOOK PLACE PRIOR TO THE RETORACTIVE DATE. NO COVERAGE WILL EXIST AFTER THE EXPIRATION OF THE AUTOMATIC DISCOVERY PERIOD, OR IF PURCHASED, THE ADDITIONAL DISCOVERY PERIOD, WHICH MAY RESULT IN A POTENTIAL COVERAGE GAP IF PRIOR ACTS COVERAGE IS NOT PROVIDED BY ANOTHER INSURER. DURING THE FIRST SEVERAL YEARS OF A CLAIMS MADE RELATIONSHIP, CLAIMS MADE RATES ARE COMPARATIVELY LOWER THAN OCCURRENCE RATES, AND THE INSURED CAN EXPECT SUBSTANTIAL ANNUAL PREMIUM INCREASES, INDEPENDENT OF OVERALL RATE INCREASES, UNTIL THE CLAIMS MADE RELATIONSHIP REACHES MATURITY.

GREAT AMERICAN INSURANCE COMPANIES
580 Walnut Street, Cincinnati, Ohio 45202

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Renewal Proposal Form For Non-Profit Organization Executive Protection and Employment Practices Liability Insurance

1. Name of Organization _____

   Principal Address _____

   City _____ State _____ Zip Code _____

2. The officer designated as agent of the Organization and all of the Insureds to receive any and all notices from the Insurer or an authorized representative concerning this insurance:

   _____ _____
   Name *Title*

3. a. Number of Employees _____ b. Annual Salary/Wages Expense $ _____ c. Total Assets _____

4. Provide the following information on all Subsidiaries. If "None", please indicate: ☐ None
   (a) Name; (b) Date of acquisition/creation; (c)Percent of control; (d) Nature of operation; (e) Operated for profit or non-profit; and (f) Name of parent organization. Please attach the most recent annual report or annual audit/examination or internal financial statement for each Subsidiary.

COVERAGE IS NOT AUTOMATICALLY PROVIDED FOR ALL SUBSIDIARIES. TERMS AND CONDITIONS OF COVERAGE FOR SUBSIDIARIES ARE DETAILED IN SECTION III D.

5. Provide the following information if a Condo/Homeowners Association: (If not, skip to question 6)

   a. No. of Units/Lots_____ b. Average Unit/Lot Value _____ c. % of Units/Lots Sold_____

	YES	NO
d. Has there been any change in control of the Association or representation of the Builder/Developer on the Association's Board of Directors or other governing body during the last Policy Period? *If "Yes", please attach details.*	☐	☐
6. Has there been any change in the Organization's legal structure, purpose(s), tax status or the nature of operations during the Policy Period? *If "Yes", attach details.*	☐	☐
7. Have there been in the last Policy Period any changes in senior management (Executive Director, President, Executive Vice President, etc.) for reasons other than death or retirement at the normal retirement age or term limitations? *If "Yes", please attach details.*	☐	☐
8. a. What was the approximate turnover rate for employees in the last twelve months? _____%		
b. Did the turnover rate of employees exceed that from the previous Policy Period? If *"Yes", please attach details*	☐	☐
9. Is the Organization or any of its Subsidiaries involved in or presently considering any merger, consolidation, acquisition, divestment or sale of a portion of its business or has a similar transaction been considered or completed during the last Policy Period? *If "Yes", please attach details.*	☐	☐
10. Does the Organization or any proposed Insured perform any of the following: a. Promote, sponsor or provide any form of insurance to members or non-members?	☐	☐
b. Take any disciplinary action or recommend disciplinary action as a result of peer review or standard setting activities?	☐	☐
c. Engage in any labor negotiations?	☐	☐
d. Provide any other professional services?	☐	☐
e. Engage in any business transactions with businesses which are controlled by any Insured Persons?	☐	☐

	YES	NO
f. Engage in any form of research, development or experimentation? *If "Yes", for any of the above, please attach details*	☐	☐

The undersigned President (or Executive Director) declares that to the best of his/her knowledge the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information from each and every proposed Insured to facilitate the proper and accurate completion of this Proposal Form. The undersigned further agrees that if any significant adverse change in the condition of the applicant is discovered between the date of this Proposal Form and the effective date of the Policy, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the Insurer immediately. The signing of this Proposal Form does not bind the undersigned to purchase the insurance, but it is agreed that this Proposal Form and any material submitted therewith are their representations. It is further agreed that this Proposal Form and any material submitted therewith shall be the basis of the contract should a Policy be issued, and this Proposal Form and any attachments thereto will be attached to and become a part of the Policy.

It is represented that the particulars and statements contained in the Proposal Form are true and are the basis of this Policy and are to be considered as incorporated in and constituting part of this Policy. However, this Policy shall not be voided or rescinded and coverage shall not be excluded as a result of any untrue statement in the Proposal Form, except as to the Organization, its Subsidiaries and those Insured Persons making such untrue statement or having knowledge of its untruth.

INSURANCE FRAUD REQUIRED WARNING STATEMENT: 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 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.

By _____ Date _____

SIGNATURE OF PRESIDENT OR EXECUTIVE DIRECTOR

Title _____

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

PLEASE NOTE: A copy of the Organization's latest annual report or annual audit/examination or internal financial statement must be provided at the time the completed Proposal Form is submitted. This Proposal, including any material submitted therewith, shall be treated in strictest confidence.

Please submit this Proposal Form including documentation to:

GREAT AMERICAN INSURANCE COMPANIES
EXECUTIVE LIABILITY DIVISION
P.O. BOX 66943
CHICAGO, ILLINOIS 60666

Important: Use the print button to keep a copy for your records. The submit button will e-mail a copy to the address(es) provided below.

Broker/Agent Name (Required) _____

Broker/Agent Email Address (Required) _____

Broker/Agent Phone Number (Required) _____

Insured's Name (Optional) _____

Insured's Contact Email (Optional) _____

Insured's Phone Number (Optional) _____

Print **Reset**