

**SOLIDARITY PROTECTION GROUP**

a voluntary membership organization operating pursuant to the Liability Risk Retention Act of 1986 and whose principal office is:  
4323 Warren Street, NW, Washington, DC 20016-2437

**FIDUCIARY LIABILITY INSURANCE NEW BUSINESS APPLICATION**

The policy for which application is made is written on a claims-made basis. The coverage afforded by this policy is limited to liability for only those claims first made during the policy period specified on the Policy Certificate resulting from wrongful acts and which are subsequently reported to the Insurer as soon as practicable. This is a policy with claims expenses included in the limits of liability. The limits of liability shall be reduced and may be exhausted by claims expenses, and to the extent that the limits of liability are thereby exceeded, the Insurer shall not be liable for claims expenses or any other loss. Please read everything carefully.

**I. GENERAL INFORMATION**

Name of Plan: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

EIN Number: \_\_\_\_\_ Date the Plan was established: \_\_\_\_\_

Insurance Representative: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

<u>Prior Insurance Carrier(s):</u>	<u>Policy Period:</u>	<u>Limit of Liability:</u>	<u>Retention:</u>	<u>Premium:</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If no prior coverage, check here: \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_

Requested Limit of Liability: \_\_\_\_\_ Requested Retention: \_\_\_\_\_

Number of current trustees of the Plan: \_\_\_\_\_

Number of current employees of the Plan: \_\_\_\_\_

	<u>Name of Service Provider:</u>	<u>Years of Service:</u>
Professional Administrator:	_____	_____
Legal Counsel:	_____	_____
Actuary:	_____	_____
Certified Public Accountant:	_____	_____
Custodian of Assets:	_____	_____
Investment Manager(s):	_____	_____

## II. UNDERWRITING QUESTIONS

### A. Plan Management (if any question is answered 'No' a written attachment is required)

1. How often does the board of trustees meet? \_\_\_\_\_
2. Does the board of trustees adhere to written guidelines to periodically review each service provider's performance? Yes\_\_\_ No\_\_\_
3. Does the board of trustees adhere to written guidelines to periodically review any fees or commissions charged to or paid by the Plan? Yes\_\_\_ No\_\_\_
4. Do the board of trustees and investment manager(s) adhere to written guidelines? Yes\_\_\_ No\_\_\_
5. How often is each investment manager's performance monitored? \_\_\_\_\_
6. Does the board of trustees have a written procedure to collect overdue and delinquent employer contributions? Yes\_\_\_ No\_\_\_

### B. Plan Changes (if any question is answered 'Yes' a written attachment is required)

1. Has the legal name of the Plan changed or is such a change being anticipated? Yes\_\_\_ No\_\_\_
2. Has any other plan been merged into the Plan in the past 12 months or is such a merger being anticipated in the next 12 months? Yes\_\_\_ No\_\_\_
3. Has the Plan terminated or is a termination anticipated in the next 12 months? Yes\_\_\_ No\_\_\_
4. Have there been any amendments to the Plan in the past 12 months that resulted in a reduction in benefits, or are any such amendments anticipated in the next 12 months? Yes\_\_\_ No\_\_\_

### C. Compliance (if any question is answered 'No' a written attachment is required)

1. Does the Plan conform to the standards of eligibility, participation, vesting, funding and other provisions of ERISA? Yes\_\_\_ No\_\_\_
2. Has the Plan been reviewed to assure that there are no violations of prohibited transactions and party-in-interest rules? Yes\_\_\_ No\_\_\_
3. Has the Plan filed for an exemption from a prohibited transaction? Yes\_\_\_ No\_\_\_
4. Has the IRS withdrawn or threatened to withdraw the Plan's tax-exempt status? Yes\_\_\_ No\_\_\_
5. Are there any overdue, outstanding or delinquent employer contributions? Yes\_\_\_ No\_\_\_
6. Does the Plan have current coverage under an ERISA fidelity bond? Yes\_\_\_ No\_\_\_
7. Has the actuary certified that the Plan is adequately funded under ERISA? Yes\_\_\_ No\_\_\_  
If No, in how many years will adequate funding be achieved? \_\_\_\_\_

### D. Loss History (if any question is answered 'Yes' a written attachment is required)

1. Has any trustee or employee of the Plan been:
  - a. accused, found guilty or held liable for a breach of trust or fiduciary duty (including violations of ERISA)? Yes\_\_\_ No\_\_\_
  - b. accused or convicted of criminal conduct? Yes\_\_\_ No\_\_\_
  - c. refused coverage under a fidelity bond? Yes\_\_\_ No\_\_\_
2. Are there any current claims outstanding against the Plan or any fiduciaries? Yes\_\_\_ No\_\_\_

3. Have any claims been made against the Plan or any fiduciaries in the past 6 years? Yes\_\_\_ No\_\_\_
4. Has the Plan received any communication from or been the subject of any investigation or audit by the IRS, DOL or any other regulatory agency? Yes\_\_\_ No\_\_\_
5. Has the Plan experienced a reportable transaction to the PBGC? Yes\_\_\_ No\_\_\_
6. Has any application for fiduciary liability coverage or fidelity bond insurance been declined, canceled or non-renewed? Yes\_\_\_ No\_\_\_
7. Does the Plan, the board of trustees, current employees or any other proposed fiduciary have any knowledge of or information pertaining to any facts, events or circumstances which may result in a claim being made against them under the proposed policy? Yes\_\_\_ No\_\_\_

It is agreed that, if knowledge of any facts, events or circumstances exist, whether or not disclosed, any claim based upon or arising from them, and that any claim based upon or arising from any pending or prior proceeding, is excluded from the proposed coverage.

### III. REQUIRED ATTACHMENTS

The following information must be attached for each Plan to be covered under the proposed policy:

- Names of the current trustees
- Most recent Audited Financial Statements completed by the CPA
- Most recent Form 5500s or 990s, including all schedules
- Most recent Actuarial Zone Certification and applicable Funding Improvement/Rehabilitation Plan as required by the Pension Protection Act of 2006 (only for defined benefit pension plans)
- Required attachments to underwriting questions, if any

### IV. SIGNATURE

The undersigned represents, that to the best of his/her knowledge and belief the statements set forth herein are true, and he/she has not withheld any information which is reasonably likely to influence the judgment of Hudson Insurance Company in considering this application for fiduciary liability insurance. The undersigned further represents that if the information supplied on this application changes between the date of this application and the effective date of the insurance or the time when the policy is bound (whichever is later), the undersigned will immediately notify Hudson Insurance Company in writing of such changes and Hudson Insurance Company may withdraw or modify any outstanding quotations based upon such changes. The signing of this application does not bind Hudson Insurance Company to complete the insurance, but it is agreed that this application and any attachments form the basis of the contract should a policy be issued and shall be deemed attached to and form part of a policy. Hudson Insurance Company is hereby authorized to make any investigation and inquiry in connection with this application it deems necessary.

**Signature of Trustee / Administrator:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Trustee / Administrator (please print):** \_\_\_\_\_

This application must be completed, signed and dated in order to bind coverage. Please submit this application and all required attachments to your Insurance Representative.

Insurance Representative, please submit this application and all required attachments to:

Euclid Specialty Managers, LLC  
 2701 Prosperity Avenue, Suite 220  
 Fairfax, VA 22031  
 (571) 730-4810 (phone)  
 (571) 730-4813 (fax)

## V. FRAUD WARNINGS

**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 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.

**NOTICE TO OREGON APPLICANTS:** Any person who knowingly and with intent to injure, deceive, defraud any insurer or other person files an application or a claim containing any false, incomplete or misleading information or conceals information concerning any material fact may be guilty of insurance fraud, which is a crime and may subject 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 APPLICANTS IN AR, FL, KY, MN, NJ, OK, AND 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.

**NOTICE TO ALL OTHER APPLICANTS:** Any person who knowingly and with intent to injure, deceive, defraud any insurer or other person files an application or a claim containing any false, incomplete or misleading information or conceals information concerning any material fact commits insurance fraud, which is a crime and subjects such person to criminal and civil penalties.

CLAIMS INFORMATION

A. Provide:

- 1. Name of Claimant: \_\_\_\_\_
- 2. Date of Alleged Wrongful Act: \_\_\_\_\_  
Date claim was made: \_\_\_\_\_
- 3. Date reported to Fiduciary Liability Insurer: \_\_\_\_\_
- 4. Name of Fiduciary Liability Insurer: \_\_\_\_\_
- 5. Allegation: \_\_\_\_\_

B. Describe the claim, including the alleged wrongful act, the event that led to the claim, and the current status of the claim:

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Claim Fee Information:

Total Loss: \$ \_\_\_\_\_ Claimant Demand: \$ \_\_\_\_\_  
 Legal Fees Charged to Date: \$ \_\_\_\_\_

C. What loss prevention measures, if applicable, have been taken to prevent a similar claim from recurring?

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