



UNITED STATES LIABILITY INSURANCE GROUP

Non Profit Professional Liability

A P P L I C A T I O N

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

Application for Non Profit Directors & Officers Liability Insurance (Coverage Part A) and Employment Practices Liability Insurance (Optional Coverage Part B).

PART 1. BACKGROUND INFORMATION

1. Name of Organization: _____
Address: _____
 2. Purpose of Organization: _____
 3. In continuous existence since: 19 _____
 4. Are there subsidiaries? Yes No If yes, provide name(s), date established, nature of operation, profit or nonprofit, purpose, bylaws and Financial statements for each subsidiary: _____

- If yes, is coverage requested for them? Yes No

PART 2. INSURANCE COVERAGE INFORMATION

5. a) Directors and Officers Liability Insurance carried:

Insurer	Limits of Liability	Premium	Deductible	Policy Period
- b) Directors & Officers Liability Insurance has been continuously in force since _____
6. Does the Organization currently carry General Liability Insurance? Yes No
7. Has any Policy for Directors and Officers Liability Insurance ever been canceled or non-renewed?
Yes No If yes, please advise details: _____
8. The individual of the Organization designated to receive any and all notices from the Insurer or their authorized representative(s) concerning this insurance is:
Name _____ Title _____
9. Number of members: _____ Number of Chapters _____
If there are chapters, is coverage requested for them under this Policy? Yes No

PART 3. ORGANIZATION OPERATION DETAILS

Please Attach a Statement of Details to All "Yes" Answers to Questions #10-14

10. Is the Organization involved in product research, development, testing and/or certification? Yes No
11. Does the Organization engage in any disciplinary actions as a result of peer review activities? Yes No
12. Does the Organization administer or sponsor any insurance programs? Yes No
13. Is the Organization involved in any accreditation or standard setting activities? Yes No
14. Is the Organization involved in any labor/union negotiations or collective bargaining activities? Yes No

PART 4. EMPLOYER DETAILS

15. Total Number of: Full time Employees? _____ Part time Employees? _____
16. Does the organization have a written: Anti-Sexual Harassment Policy? Yes No
Anti-Discrimination Policy? Yes No If Yes, please attach a copy.
17. Has there been any reduction of employees in the past 12 months or is a reduction anticipated in the next 12 months?
Yes No If Yes, what percentage? _____

PART 5. CLAIM INFORMATION

Do not complete this section if this is an application for a renewal policy at the same limit of liability with one of the USLI Companies.

18. Within the last 5 years, has any inquiry, complaint, notice of hearing, claim or suit been made (including, but not limited to, Equal Employment Opportunity Commission, State Human Rights Boards, Municipal, State or Federal Regulatory Authorities), against the Organization, or any person proposed for Insurance in the capacity of either Director, Officer, Trustee, Employee or Volunteer of the Organization? Yes No
19. Is any person proposed for this insurance aware of any fact, circumstance or situation which may result in a claim against the organization or any of its Directors, Trustees, Officers, Employees or Volunteers? Yes No
If Yes, please explain: _____

Please sign and Date Application on 2nd Page.

PART 6. FINANCIAL INFORMATION

Annual Revenues (past 12 months) \$ _____

Projected Annual Revenues (next 12 months) \$ _____

Fund Balance (Total Assets – Total Liabilities) \$ _____ Is Fund Balance Positive _____ or Negative _____?

PART 7. RENEWAL STATEMENT

APPLICABLE TO RENEWAL POLICIES ONLY

It is agreed that this Renewal Application is a supplement to the Application(s) attached to the current Policy and said Applications, together with this Renewal Application, constitute the complete Application which shall be the basis of the contract should a Policy be issued and will be attached to and become part of the Policy.

PART 8. REQUIRED INFORMATION

- A. Completed Application signed and dated by either the President or Chairman of the Board.
- B. Latest Audited Financial Statement. (If financial statement is not audited, attach unaudited 12 month financial statement or a 990 Tax Form).
- C. Purpose statement from Bylaws or summary of operations/brochure.

FRAUD 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, 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 THOUSANDS DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

The undersigned declares that to the best of his/her knowledge and belief the statements set forth herein are true. The undersigned further declares that any occurrence or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Insurer and the Insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. 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.

Signature _____
(Chairman of the Board or President)

Title: _____ Date: _____

SUPPLEMENTAL CLAIMS APPLICATION

When any one of the Claims Questions is answered "Yes", please complete this form for **each Claim**.

1. Name of Claimant? _____

2. When did Claim occur? _____

3. Details and background of Claim _____

4. Has the EEOC or State Human Rights Agency ruled on this case? Yes _____ No _____ .

If Yes, was ruling A. Probable Cause _____ B. No Probable Cause _____

(PLEASE ATTACH A COPY OF THE RULING).

5. What is the Status of the Claim? _____

6. Amount of Defense Costs Paid? _____

7. Settlement Amount? _____

8. Was the Claim filed with Insurer? Yes _____ No _____ If Yes, was the Claim covered by Insurance? Yes _____ No _____ .

9. If Claim is still open, what amount of Reserve has been set up by the Insurer? _____

10. What remedial measures have been taken to prevent a recurrence of a similar Claim? _____

Signature: _____ Date: _____
(By President or Chairman of Board of Insured)

The information on this supplemental Application is material to the Company underwriting this risk and shall be deemed attached a part of this Policy as if physically attached hereto.

FIDUCIARY LIABILITY SUPPLEMENTAL QUESTIONNAIRE

1. Name of Organization: _____
State: _____

2. Please check all plans the Organization currently sponsors for its employees:

401K Plan _____ 403B Plan _____ Pension Plan _____ Medical/Dental _____

Life Insurance _____ Disability _____ Other: Please describe: _____.

3. If you have either a 401K, 403B, Life Insurance or Pension Plan:
 - (a) Does an Outside Investment Firm manage the Plans? Yes _____ No _____.
If Yes, how often is their performance reviewed? _____.

 - (b) Has a Lawyer, CPA or Actuary reviewed the Plans to assure there are no violations of prohibited transactions/Party-in-interest rules and to verify compliance with standards of eligibility, participation, vesting, funding and other provisions of the Employee Retirement Income Security Act of 1974 (E.R.I.S.A) and similar provisions?
Yes _____ No _____. If Yes, when was the last time Plans were reviewed? _____.

4. If you have either a Medical/Dental or Disability Plan, does an outside Administrative or Benefits Consulting Firm administer the Plan(s)? Yes _____ No _____.

5. In the past two (2) years has there been or is there now under consideration any material changes to a Plan or termination/consolidation of a Plan? Yes _____ No _____. If Yes, please attached details.

6. Has there been or is there now pending any claim(s) against any proposed Insured arising out of any Plan? Yes _____ No _____. If Yes, please attach details.

7. Does any proposed Insured have knowledge or information of any act, error or omission which might give rise to a claim under the proposed Fiduciary Liability Coverage? Yes _____ No _____. If Yes, please attach details.

The information on this supplemental questionnaire is material to the Company underwriting this risk and shall be deemed attached a part of this Policy as is physically attached hereto.

Signature: _____ Title: _____ Date: _____

Must be signed by Chairman, President or Executive Director.



NON PROFIT PROFESSIONAL LIABILITY FOR CONDOMINIUM/HOMEOWNER ASSOCIATIONS

Application for Non Profit Directors & Officers Liability Insurance

- 1. Name of Association:
Address :
2. Date Organized:
3. Date Final Unit Completed:
4. Type of Association (check one):
5. Total Number of Units:
6. Average Unit Value:
7. Percentage of Units Sold:
8. Percentage of Units Rented or Leased:
9. Commercial Occupancy (restaurant, dry cleaner, etc.)
10. Is Complex being constructed on a phase basis?
11. A.) Number of Employees:
B.) Number of Directors & Officers who are or represent the builder, developer, or agent:
C.) Number of Units owned by the developer, builder or agent:
12. Does the Organization currently carry General Liability Insurance?
13. A.) Current Directors and Officers Liability Insurance:
14. Current Annual Revenues:
15. Has any Policy for Directors and Officers Liability Insurance ever been canceled or non renewed?
16. Within the last 5 years, has any claim been made, or is any claim being made, or is any claim now pending, against the Organization, or any person proposed for Insurance in the capacity of either Director, Officer, Trustee, Employee or Volunteer of the Organization?
17. Is any person proposed for this Insurance aware of any fact, circumstance or situation which may result in a claim against the organization or any of its Directors, Trustees, Officers, Employees or Volunteers?

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The undersigned declares that to the best of his/her knowledge and belief the statements set forth herein are true. The undersigned further declares that any occurrence or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will be immediately reported in writing to the Insurer and the Insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statement 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.

Signature (Chairman of the Board or President)

Title: Date:

1030 Continental Drive * PO Box 1551
Telephone (610) 688-2535



King of Prussia, PA 19406-0951
Facsimile (610) 688-4391

CLAIM WARRANTY LETTER

The undersigned declares that no claim has been made (except claims, if any, previously disclosed on USLI application), nor is any claim now pending, or is any person proposed for this Insurance aware of any fact, circumstance or situation which may result in a claim against the Organization or any other individual insureds.

Name of Insured _____

Signature _____
Chairman of the Board or President

Title: _____

Date: _____

(FAX

NAME: _____
COMPANY: _____
ADDRESS: _____
STATE, ZIP: _____
DATE: _____
NUMBER OF PAGES(incl. Cover): _____
* FAX TO: _____

PLEASE FAX THIS APPLICATION TO THE OFFICE THAT IS NEAREST YOU.

* Click the link below for a list of our offices and current fax numbers.

<http://www.qsr-insurance.com/qsr-fax.html>

ADDITIONAL COMMENTS:

