



**Application For
ACE EXPRESS Non Profit Organization
Management Indemnity Package**

NOTICE: THE POLICY FOR WHICH APPLICATION IS MADE, SUBJECT TO ITS TERMS, APPLIES ONLY TO ANY CLAIM MADE AGAINST ANY OF THE INSURED DURING THE POLICY PERIOD. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS SHALL BE REDUCED AND MAY BE EXHAUSTED BY AMOUNTS INCURRED AS COSTS, CHARGES AND EXPENSES (AS DEFINED IN THE COVERAGE SECTION FOR WHICH APPLICATION IS MADE), AND COSTS, CHARGES AND EXPENSES SHALL BE APPLIED TO THE RETENTIONS.

General Instructions for Completing This Application

1. Please type or print in ink.
2. Please read carefully and answer all questions. If a question is not applicable, so state.
3. The Application must be signed by an executive officer.
4. This Application and all exhibits shall be held in confidence.
5. Please read the Policy for which application is made (the "Policy") prior to completing this Application.
6. The terms as used herein shall have the meanings as defined in the Policy.

I. General Information

1. Name of Organization: _____

Address: _____

(Number) (Street)

(City) (State) (Zip Code)

Officer designated to receive correspondence and notices from the Insurer:

Name: _____

Title: _____

Phone Number: _____

2. Internal Revenue Service Code: _____

3. Nature of Operations:

- | | |
|--|--|
| <input type="checkbox"/> Ballet/Opera/Theatre Company | <input type="checkbox"/> Health System |
| <input type="checkbox"/> Blood Bank/Tissue Bank | <input type="checkbox"/> Hospitals/HMO/PPO |
| <input type="checkbox"/> Camp | <input type="checkbox"/> Labor Union |
| <input type="checkbox"/> Chamber of Commerce | <input type="checkbox"/> Museums/Libraries/Aquarium/Zoo |
| <input type="checkbox"/> Charitable Organization/Shelter | <input type="checkbox"/> Assisted Living Facility/Nursing Home |
| <input type="checkbox"/> Child Care/Day Care/Elder Care Facility | <input type="checkbox"/> Religious Organizations/Church |
| <input type="checkbox"/> Colleges and Universities | <input type="checkbox"/> Research/Development Institute |
| <input type="checkbox"/> Community Development Organization | <input type="checkbox"/> Social or Recreational Club |
| <input type="checkbox"/> Community Health Centers | <input type="checkbox"/> Social Welfare Organization |
| <input type="checkbox"/> Convention Center | <input type="checkbox"/> Sports Associations |
| <input type="checkbox"/> Cooperatives | <input type="checkbox"/> Trade Association Non-Credentialing |
| <input type="checkbox"/> Family Planning Center | <input type="checkbox"/> Trade Associations Credentialing |
| <input type="checkbox"/> Foundation | <input type="checkbox"/> Trusts |
| <input type="checkbox"/> Fraternal Society or Association | <input type="checkbox"/> Veterans Association |
| <input type="checkbox"/> Golf or Country Club | <input type="checkbox"/> Yacht Club |
| <input type="checkbox"/> Other (please specify): | |

4. Has the Organization been in operation longer than three (3) years? Yes No

5. Is the Organization involved in any labor/union negotiations or collective bargaining activities? Yes No

II. Prior Insurance Information and Activities Information

1. Describe any current insurance maintained. The Continuity Date below means the policy inception date for which the most recent main form application was attached.

<u>Coverage</u>	<u>Yes</u>	<u>No</u>	<u>Limits</u>	<u>Continuity Date</u>
Employment Practices Liability	<input type="checkbox"/>	<input type="checkbox"/>		
Insured Persons and Organization Liability	<input type="checkbox"/>	<input type="checkbox"/>		

FRAUD WARNING STATEMENTS

NOTICE TO ARKANSAS, LOUISIANA 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 (or any supplemental application, questionnaire or similar document) containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment or loss or benefit is a crime punishable by fines or imprisonment, or both.

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 a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 MINNESOTA APPLICANTS: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 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 and the stated value of the claim for each such violation.

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 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 OREGON APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

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, VIRGINIA AND WASHINGTON 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 ALL APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO APPLICANTS. PLEASE READ CAREFULLY

BY SIGNING THIS APPLICATION, THE APPLICANT, ON BEHALF OF ALL PROPOSED INSURED, WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ATTACHMENTS HERETO ABOUT THE APPLICANT, ITS SUBSIDIARIES, AND THEIR OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED, OMITTED, SUPPRESSED, CONCEALED, OR MISREPRESENTED IN THIS APPLICATION OR ITS ATTACHMENTS . THE APPLICANT UNDERSTANDS AND AGREES THAT IF, AFTER THE DATE OF THIS APPLICATION AND PRIOR TO THE EFFECTIVE DATE OF ANY POLICY BASED ON THIS APPLICATION AND ATTACHMENTS, ANY OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE INSURANCE MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT UNDERSTANDS AND AGREES THAT THE COMPANY, IN PROPOSING TO PROVIDE INSURANCE, HAS RELIED ON THIS APPLICATION AND ALL ATTACHMENTS, AND THAT THIS APPLICATION AND ALL ATTACHMENTS ,ARE (1) MATERIAL AND THE BASIS OF THE CONTRACT WITH THE COMPANY, AND (2) DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

THE UNDERSIGNED OFFICER OF THE APPLICANT CERTIFIES AND WARRANTS THAT HE/SHE IS DULY AUTHORIZED TO EXECUTE THIS APPLICATION ON BEHALF OF THE APPLICANT AND ITS SUBSIDIARIES.

Applicant's Signature:

(Must be signed by an Officer of the Applicant)

Print Name and Title

____/____/____
Date (Mo./Day/Yr.)

Please fully complete and attach the Information for the Coverage Section (s) desired.

Employment Practices Coverage Section Information

Is the Organization seeking Employment Practices coverage? If yes, please answer the following questions. Yes No

1. Total number of employees: Full-Time: _____
Part-Time: _____
Temporary, Seasonal: _____
Leased: _____
Independent Contractors: _____
Volunteers: _____

2. Does the organization anticipate in the next 12 months, or has the Organization transacted in the last 12 months, any consolidations or layoffs affecting 35% or more of the employee or Volunteers of the Organization? Yes No

3. Describe the internal controls the Company maintains for Employment Practices.

a) Does the Company publish and distribute an employee handbook to every employee? Yes No

b) Are there written procedures for handling employee complaints of discrimination or sexual harassment? Yes No

c) Are there written procedures for handling employee grievances or complaints? Yes No

4. Please provide the following information for the Risk Manager/Human Resource Manager (or equivalent position) of the Company:

Name: _____ Direct Phone Number: _____

Title: _____ Fax Number: _____

E-mail Address: _____

Insured Person and Organization Coverage Section Information

1. Number of for-profit subsidiaries the Organization owns: _____ Exact number if more than 1