



# Philadelphia Insurance Companies

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## NON-PROFIT DIRECTORS AND OFFICERS LIABILITY INSURANCE

THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY

PLEASE READ YOUR POLICY CAREFULLY

### PART I - GENERAL INFORMATION

1. Name: \_\_\_\_\_
2. Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_
3. Purpose: \_\_\_\_\_  
\_\_\_\_\_
4. Date Organized: \_\_\_\_\_ Date of Incorporation: \_\_\_\_\_
5. Does the Organization have any subsidiaries or control any other entity or organizations?  
If YES please attach a description of the operation, ownership and tax status of each entity. Yes  No
6. Are the financial affairs of the Organization audited annually by a Certified Public Accountant? Yes  No
7. Does the Organization have a tax exempt status under the U.S. Internal Revenue Code? Yes  No
8. How often does the board meet? \_\_\_\_\_ Is there an attendance requirement? Yes  No
9. The Officer of the Organization designated to receive any and all notices from the Insurer or their authorized representative (s) concerning this insurance is: Name: \_\_\_\_\_ Title: \_\_\_\_\_

### PART II - ACTIVITIES OF THE ORGANIZATION

10. Number of members: \_\_\_\_\_ Number of Chapters: \_\_\_\_\_ Yes  No
11. Does the Organization publish any magazines, periodicals or newsletters?  
Please attach a copy of each. Yes  No

PLEASE ATTACH A STATEMENT OF DETAILS FOR ALL "YES" ANSWERS TO QUESTIONS #12-15

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 12. Is the Association involved in product research, product development, testing and/or certification?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does the Association set standards for the qualification and performance and/or certify its members? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does the Association engage in any disciplinary actions as a result of peer review activities?       | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the Association administer or sponsor any insurance programs for its members?                   | <input type="checkbox"/> | <input type="checkbox"/> |

**PART III - INSURANCE COVERAGE**

**DIRECTORS & OFFICERS LIABILITY COVERAGE**

16a.

	INSURER	LIMIT	DEDUCTIBLE	PREMIUM	TERM
<i>EXPIRING</i>					
<i>PREVIOUS</i>					
<i>EARLIEST</i>					

16b. Director's and Officer's Liability Insurance has been continuously in force since: \_\_\_\_\_

17. Does the Applicant carry General Liability Insurance? **Yes** **No**  
 If yes - Carrier Name: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**PART IV - EMPLOYER DETAILS**

18. Current number of employees: Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_  
 Number of tenured faculty (if applicable): \_\_\_\_\_ **Yes** **No**

19. Do you use an employment application for all your applicants for hire?

20. Do you have an employment handbook?

21. Do you have an "At Will" provision in the employment application?  
 In the employment handbook?

22. How many employees have been terminated or demoted in the past 12 months? \_\_\_\_\_  
 Voluntary: \_\_\_\_\_ Involuntary: \_\_\_\_\_ Laid off: \_\_\_\_\_ Demoted: \_\_\_\_\_

23. Is any reduction of employees or change of status anticipated in the next year?  
 Voluntary: \_\_\_\_\_ Involuntary: \_\_\_\_\_ Lay offs: \_\_\_\_\_ Demoted: \_\_\_\_\_

**PART V - CLAIM INFORMATION**

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

**Any question answered yes, must be explained on a supplemental form.**

24. Has the Applicant been involved in any grievance or other administrative proceeding before any of the following agencies and/or under any of the following acts in the last 5 years:

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
NATIONAL LABOR RELATIONS BOARD	<input type="checkbox"/>	<input type="checkbox"/>	FEDERAL LABOR STANDARDS ACT	<input type="checkbox"/>	<input type="checkbox"/>
FAIR LABOR STANDARDS ENFORCEMENT ACT	<input type="checkbox"/>	<input type="checkbox"/>	U.S. DEPARTMENT OF LABOR	<input type="checkbox"/>	<input type="checkbox"/>
AMERICANS WITH DISABILITIES ACT	<input type="checkbox"/>	<input type="checkbox"/>	CIVIL RIGHTS ACT OF 1991	<input type="checkbox"/>	<input type="checkbox"/>
AGE DISCRIMINATION IN EMPLOYMENT ACT	<input type="checkbox"/>	<input type="checkbox"/>	CIVIL RIGHTS ACT OF 1964	<input type="checkbox"/>	<input type="checkbox"/>
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION	<input type="checkbox"/>	<input type="checkbox"/>	OTHER FEDERAL/ STATE/LOCAL AGENCY	<input type="checkbox"/>	<input type="checkbox"/>

**PART V CONT'D - CLAIM INFORMATION** Do not complete this section if this is an application for a

25. Within the last 5 years, has any claim been made, or is now pending, against the Organization, or any person proposed for Insurance in the capacity of either Director, Trustee, Officer or Employee ?  
 Yes  No **If Yes, a supplemental form must be completed and will form a part of this application.**
26. Is any person proposed for this insurance cognizant of any fact, circumstance or situation, which may result in a claim against the Organization or any of its Directors, Trustees, Officers or Employees?  
 Yes  No **If Yes, a supplemental form must be completed and will form a part of this application.**

**PART VI - 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 all previous policies issued by the Company providing continuous coverage and said Applications (including this renewal application) and any material submitted therewith constitute the complete Application which shall be the basis of the contract should a policy be issued and shall be deemed a part of such policy as if physically attached thereto.

**PART VII - REQUIRED INFORMATION**

- A. Completed application signed by the Chairman of the Board, President or Executive Director.
- B. Bylaws and/or Articles of Incorporation.
- C. Latest Annual Report or CPA Audit of each organization including subsidiaries, which are to be covered by this insurance.
- D. Schedule of Directors and Officers.
- E. Supplemental form if questions 24,25 or 26 are answered yes.

The Undersigned warrants 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 to make any investigation and inquiry in connection with the information, statements and disclosures provided in this proposal. The signing of this proposal does not bind the undersigned to purchase the insurance, nor does the review of this proposal bind the insurance company to issue a policy. It is agreed that this proposal shall be the basis of the contract should a policy be issued and it will be attached and become a part of the policy. The undersigned warrants that he /she is authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the Organization, its subsidiaries and their respective directors, officers or other Insured Persons.

**WARNING: ANY PERSON WHO KNOWINGLY AND WITH THE 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 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 KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY 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 MINNESOTA AND OHIO APPLICANTS:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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, WHICH IS A CRIME.

**NOTICE TO OKLAHOMA APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKE 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 FLORIDA APPLICANTS:** ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**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.

Name: \_\_\_\_\_  
(Please Print)

Title: \_\_\_\_\_  
(President, Chairman or Executive Director)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## Submitter's Contact Information

If this form is being submitted by someone other than the Insured, please provide the submitter's contact information below.

Company Name

Contact Person

Address

Phone

Fax

Email