

Executive ViewPoint (EVP) Private Company Management Liability New Business Application

NOTICE: THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. COVERAGE ONLY APPLIES TO CLAIMS AS DEFINED IN THE POLICY THAT ARE FIRST MADE DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD AND ARE REPORTED TO THE "COMPANY" ACCORDING TO THE TERMS AND CONDITIONS OF THE POLICY. READ YOUR POLICY CAREFULLY. THE LIMITS OF LIABILITY WILL BE REDUCED BY, AND MAY BE COMPLETELY EXHAUSTED BY, DEFENSE COSTS. DEFENSE COSTS WILL BE APPLIED AGAINST THE RETENTION.

Whenever used in this Application, the term "**Named Applicant**" refers to the entity named in Section I. line 1. and all subsidiaries of **Named Applicant**, unless otherwise indicated. **Named Applicant** on Section I. line 1. will be the Named Insured on the Policy and must be the parent company of all subsidiaries to be covered. "Company" means the insurance company issuing the policy that provides the coverage(s) requested in this Application.

INSTRUCTIONS

- All questions must be answered unless otherwise indicated, and this Application must be signed by the Chairperson, CEO, CFO, or In-House General Counsel.
- Employee count and financial information should be provided on a consolidated basis for the **Named Applicant** and subsidiaries seeking coverage.
- Please attach most recent loss runs in the past five (5) years as well as the following for the requested coverage(s):

Directors and Officers Liability

- Most recent year-end audited or CPA prepared financial statement of the **Named Applicant**. If more than six (6) months old, please attach most recent company prepared interim financial statements as well.
- List all shareholders, indicating percentage owned and which are directors, officers or employees of the **Named Applicant**.
- List directors and officers of **Named Applicant** and identify any outside directorships or officerships, if applicable.

Employment Practices Liability

- Most recent Employer Information Report (EEO-1), if required by law.

Fiduciary Liability

- Most recent independent actuarial valuation if a **Named Applicant** sponsors an ESOP or KSOP.
- Most recent audited financial statements of any ESOP, KSOP or Defined Benefit plans sponsored by the **Named Applicant**.
- Most recent year-end audited or CPA prepared financial statement of the **Named Applicant**.

I. APPLICANT INFORMATION

- Named Applicant** to be the Named Insured on the Policy Declarations:

Primary Address (No P.O. Box):

Street Address _____ City _____ State _____ Zip Code _____

Website address: _____

- Business type: Corporation LLC Sole Proprietorship Partnership Other _____

3. Primary NAICS Code: _____

4. Years in operation: _____

5. Description of operations: _____

- Does the **Named Applicant** have any subsidiaries? Yes No

If "Yes" please attach a list of all subsidiaries including: location, operations, ownership, total revenues and number of employees.

- Does the **Named Applicant** want coverage for the subsidiaries? N/A Yes No

II. COVERAGE REQUESTED

1. Please indicate, by checking the box, which coverages are being requested, and complete the relevant portions of the chart.

| Coverage | Limits Requested | Current Policy in Effect? | Current Limits of Liability | Current Retention | Current Insurer | Current Prior and Pending Date |
|---|------------------|--|-----------------------------|-------------------|-----------------|--------------------------------|
| <input type="checkbox"/> Directors and Officers Liability | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ | \$ | | |
| <input type="checkbox"/> Employment Practices Liability | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ | \$ | | |
| <input type="checkbox"/> Fiduciary Liability | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ | \$ | | |

2. Have any of the insurers of the respective coverages listed above indicated an intent to non-renew? Yes No
(QUESTION NOT APPLICABLE IN MISSOURI) *If "Yes" please attach details.*

III. GENERAL INFORMATION

1. Have any of the following occurred in the last twelve (12) months or are planned for the next eighteen (18) months by **Named Applicant**?

- a. Merger, acquisition, formation or divesting of a subsidiary Yes No
- b. Senior management changes for reasons other than term expiration, death or retirement Yes No
- c. Layoffs, staff reductions or facility closings Yes No
If "Yes," indicate percentage of total workforce affected _____ %
- d. Bankruptcy filing, work-out arrangements with creditors, reorganization or restructuring Yes No

2. Does the **Named Applicant** have any foreign operations and/or foreign subsidiaries? Yes No
If "Yes," indicate percentage of total revenues generated by all foreign operations _____ %

3. Is the **Named Applicant** a federal or state contractor? Yes No
If "Yes" to any of the above questions 1. - 3., please attach details.

IV. FINANCIAL INFORMATION

1. Please complete the following chart. If all information requested is included in financial statements provided with this Application, skip to question 2.

As of the most recent year end: month _____ year _____

| | | | |
|---------------------|----|---|----|
| Current Assets | \$ | Shareholders' Equity | \$ |
| Total Assets | \$ | Revenues | \$ |
| Current Liabilities | \$ | Earnings Before Interest and Taxes (EBIT) | \$ |
| Long Term Debt | \$ | Net Income | \$ |
| Total Liabilities | \$ | Cash Flow from Operations | \$ |
| Retained Earnings | \$ | | |

2. Has the **Named Applicant** changed auditors in the last twelve (12) months? Yes No

3. Is the **Named Applicant** on notice of a violation of any debt covenants? Yes No

4. Has the **Named Applicant** ever received an adverse opinion from an auditor including but not limited to an opinion expressing doubt as to an ability to continue as a "going concern"? Yes No

If "Yes" to any of the above questions 2. - 4., please attach details.

V. CLAIM INFORMATION

1. Has any claim or notice of potential claim been given to any insurer for any of the requested coverages listed in Section II, 1., above? Yes No

2. Within the last five (5) years, has the **Named Applicant** or any person to be covered under the Policy been the subject of or involved in any claim, demand, subpoena, notice, inquiry, proceeding, litigation, disciplinary action or investigation, alleging or based upon or arising out of any of the following?

- a. Antitrust, copyright or patent violation Yes No

- b. Deceptive or unfair trade practices, or violation of consumer protection laws Yes No
- c. Violation of federal or state securities laws Yes No
- d. Criminal proceedings, investigations or actions Yes No
- e. Regulatory or administrative actions Yes No
- f. Employment practices or labor related disputes Yes No
- g. License revocation or suspension Yes No
- h. Other civil, criminal or administrative proceeding Yes No

If "Yes" to any of the above questions 1. or 2., please attach details.

VI. DIRECTORS AND OFFICERS LIABILITY INFORMATION

1. Please complete the following regarding ownership of the **Named Applicant**.

| | |
|---|--|
| Total number of shares/membership units outstanding | |
| Total number of shareholders/members | |
| Total number of shares/membership units owned by directors and officers | |

- 2. Have there been any changes to the Board of Directors, Management Committee or Senior Management in the past three (3) years for reasons other than term expiration, death, or retirement? Yes No
- 3. Have any of the following occurred in the last twenty-four (24) months or are planned for the next twelve (12) months by **Named Applicant**:
 - a. Public offering of debt or securities? Yes No
 - b. Private offering of securities? Yes No
 - c. A crowdfunding offer as described in the Jumpstart Our Business Startups Act of 2012? Yes No

If "Yes" to any part of questions 2. or 3., please attach details.

- 4. Do any shareholders/members own directly or beneficially ten (10) percent or more of the outstanding shares? Yes No
If "Yes," answer question 5. below.
- 5. Are the shareholders/members either a director or officer, or have board representation? N/A Yes No

If "No" to question 5. above, please complete the chart below.

| Shareholder/Member Name | Percentage Owned (%) |
|-------------------------|----------------------|
| | % |
| | % |
| | % |
| | % |
| | % |

- 6. Does the **Named Applicant** have an in-force policy covering cyber risks, network security and privacy? Yes No

If "Yes," please provide name of insurer and current limits of liability: _____

VII. EMPLOYMENT PRACTICES LIABILITY INFORMATION

- 1. Total number of employees: Current: _____ 1 year ago: _____
- 2. Workforce classification breakdown: Please indicate the total number in each category.

| | |
|--|--|
| Full time (U.S.) | |
| Part time including leased/loaned, temporary and seasonal (U.S.) | |
| Interns and volunteers (U.S.) | |
| Independent Contractors (U.S.) | |
| Of the above, number located in California | |
| Located outside the U.S. | |

3. If more than 30% of the workforce is located outside of the **Named Applicant's** home state, please attach a list with each state and/or country, including total workforce in each.

4.

| Employee Salary Ranges | % in Range |
|------------------------|------------|
| Up to \$50,000 | % |
| \$50,001 – \$100,000 | % |
| Over \$100,000 | % |

5. Percentage of employees involuntarily terminated in last twelve (12) months _____%

6. Annual turnover rate of employees over the last two years:

| | | | |
|-------------|-----------------------|-------------|-----------------------|
| Year: _____ | Turnover Rate: _____% | Year: _____ | Turnover Rate: _____% |
|-------------|-----------------------|-------------|-----------------------|

7. During the past five (5) years, has the **Named Applicant** been involved in any of the following?

- a. An administrative proceeding, investigation or audit by the EEOC or similar state or local agency or by any other federal, state or local government agency concerning any employment-related claims Yes No
- b. Employment-related civil suit or claim resulting in a payment including defense costs, over \$10,000 Yes No
- c. Any claim or other action brought by or on behalf of any non-employee third parties alleging harassment, discrimination or violation of civil rights Yes No

If "Yes" to any of the above, please attach full details including date, allegations, current status, amounts incurred, including defense costs and any settlements or judgments as well as any corrective actions taken as a result.

8. Complete the following table for Guidelines, Policies and Procedures:

| Guidelines, Policies, Procedures | Formal Written Policy | Employees Sign and Acknowledge Receipt | Contained in Written Employment Application |
|--|--|--|--|
| a. Equal Employment Opportunity | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no written employment application) |
| b. Unrestricted Employment at-will | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no written employment application) |
| c. Zero tolerance for discrimination | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| d. Zero tolerance for sexual harassment | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| e. Zero tolerance for workplace harassment including bullying | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| f. A safe work environment including security from workplace violence or threats of violence | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| g. Compliance with the Americans with Disabilities Act of 1990 (ADA) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| h. Compliance with Family Medical Leave Act of 1993 (FMLA) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| i. Employee grievance procedure with right of recourse outside of management chain | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| j. Progressive discipline procedures prior to termination/discharge of employment | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| k. Regular performance evaluations | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| l. Use of company email, internet and social media | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| m. Procedures when dealing with third parties | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| n. Hiring, recruiting, interviewing and responding to employment verification requests | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| o. Conducting and using background/credit checks | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| p. For the classification of employees as exempt/nonexempt and the payment of wages including overtime | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

9. Does the **Named Applicant** have a full-time, dedicated human resources manager and/or department? Yes No
10. **Named Applicant** reviews all employment terminations with (check all that apply):
 Human resources In-house counsel Outside counsel N/A
11. Is outside legal counsel used in writing or modifying the **Named Applicant's** employment policies, employee handbook and employment application? Yes No
12. Does the **Named Applicant** use any tests to screen applicants for employment or to screen employees for continued employment or promotion (including health, medical or genetic testing)? Yes No
If "Yes," please attach details.
13. Are all of the **Named Applicant's** business locations in full compliance with ADA requirements for both employees and third parties? Yes No
14. Regular training is conducted on employment policies, including discrimination and harassment for (check all that apply):
 Employees Managers and supervisors Senior Executives N/A

VIII. FIDUCIARY LIABILITY INFORMATION

1. Please provide the following information about the **Named Applicant's** employee benefits Plan(s) ("Plan").
Only single employer qualified ERISA Plans are eligible for coverage.

| Plan Name (omit health and welfare Plans) | Type of Plan* | Plan Assets in \$ | Number of Participants |
|---|---------------|-------------------|------------------------|
| | | \$ | |
| | | \$ | |
| | | \$ | |
| | | \$ | |

**Defined Contribution(DC), Defined Benefit (DB), Employee Stock Ownership Plan (ESOP), 401K with ESOP feature (KSOP)*

2. Are all Plans established and operated in compliance with Plan documents and ERISA? Yes No
If "No," please attach details.
3. Does the **Named Applicant** solely manage Plan assets? Yes No
If "No," please attach details for any outside third-party service providers who manage assets.
4. Does any Plan hold or offer investment in the **Named Applicant's** securities? Yes No
5. During the past three (3) years or over the next twelve (12) months, has or will any Plan be terminated, merged, transferred, suspended, dissolved or converted to a cash balance? Yes No
6. In the past three (3) years, has any Plan been amended to reduce, eliminate or change eligibility for benefits, or is any such amendment planned in the next twelve (12) months? Yes No
7. Are there any outstanding or delinquent contributions owed to any Plan? Yes No
8. Has any Plan ever been investigated or audited by the U.S. Department of Labor (DOL), Internal Revenue Service (IRS), or other agency, domestic or foreign? Yes No
9. Has the **Named Applicant** entered into a voluntary compliance arrangement relating to a Plan under a program administered by the DOL, IRS or other government agency whether or not fees, fines or penalties were paid? Yes No
10. Does the **Named Applicant** purchase health care insurance through an exchange as defined in Section 1311 of the Patient Protection and Affordable Care Act, ("Act") or other exchange qualified under the Act? Yes No
11. Does the **Named Applicant** sponsor any Plans that are organized and administered outside the U.S. or are any Plans subject to any laws outside of the U.S.? Yes No
If "Yes," to any of the above questions 4. - 11., please attach details.
12. Has the **Named Applicant** or its designated administrator(s) provided all Plan documents, summary Plan descriptions, notices of amendments and other required documentation to all Plan participants as required by law? Yes No
13. Are Plan administrators evaluated for performance on, at least, an annual basis? Yes No
If "No," to questions 12. or 13., please attach details.

IX. APPLICANT CERTIFICATION: KNOWLEDGE OF PRIOR FACTS/CIRCUMSTANCES/SITUATIONS/EVENTS

Complete this Section if:

1. There is no current policy in force providing any of the coverage(s) requested in Section II; or
2. Limits of liability requested are higher than the limits of liability shown for any coverage(s) under any policy currently in force.

If 1. or 2. above do not apply, please do not complete the Certification below.

The below Certification applies only to any coverage(s) for which no policy is currently in force; and/or to any limits of liability that are greater than the limits of liability for any coverage(s) under any policy currently in force.

Certification

No person or entity proposed for coverage has knowledge of any fact, circumstance, situation, transaction or event, which he or she has reason to believe, could give rise to a claim for which coverage would be requested under a policy issued to **Named Applicant**:

- Certify with no exceptions
- Certify with the following exceptions

Named Applicant understands and agrees that if such Certification is untrue or incomplete, any claim or action based upon, arising out of, related to, or in consequence of such fact, circumstance, situation, transaction or event is not covered under any policy issued to the **Named Applicant**. All other rights and remedies of the Company are hereby reserved.

X. MATERIAL CHANGES TO APPLICATION

Named Applicant must immediately notify the Company of any material change in the information provided in this Application, including but not limited to the Applicant Certification where applicable. If such change(s) occurs before coverage is bound, Company reserves the right to withdraw or modify its quote for coverage based on such change(s).

FRAUD STATEMENTS

Alabama, Arkansas, District of Columbia, New Mexico, Rhode Island and West Virginia: 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.

Colorado Fraud Statement: 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.

Florida Fraud Statement: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas Fraud Statement: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Maine Fraud Statement: 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

Maryland Fraud Statement: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Fraud Statement: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York 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 thousand dollars and the stated value of the claim for each such violation.

Oklahoma Fraud Statement: 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.

Oregon Fraud Statement: Notice to Oregon applicants: Any person who, with intent to defraud or knowing that he is facilitation a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Kentucky, Pennsylvania AND Ohio 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 subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington Fraud Statement: 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.

Fraud Statement (All Other States): 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.

STATE NOTICES

Arizona Notice: Misrepresentations, omissions, concealment of facts and incorrect statements shall prevent recovery under the policy only if the misrepresentations, omissions, concealment of facts or incorrect statements are; fraudulent or material either to the acceptance of the risk, or to the hazard assumed by the insurer or the insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

Florida Surplus Lines Notice: (Applies only if policy is non-admitted) You are agreeing to place coverage in the surplus lines market. Superior coverage may be available in the admitted market and at a lesser cost. Persons insured by surplus lines carriers are not protected under the Florida Insurance Guaranty Act with respect to any right of recovery for the obligation of an insolvent unlicensed insurer.

Florida and Illinois Punitive Damage Notice: I understand that there is no coverage for punitive damages assessed directly against an insured under Florida and Illinois law. However, I also understand that punitive damages that are not assessed directly against an insured, also known as "vicariously assessed punitive damages", are insurable under Florida and Illinois law. Therefore, if any Policy is issued to the applicant as a result of this Application and such Policy provides coverage for punitive damages, I understand and acknowledge that the coverage for Claims brought in the State of Florida and Illinois is limited to "vicariously assessed punitive damages" and that there is no coverage for directly assessed punitive damages.

Maine Notice: The insurer is not permitted to withdraw any binder once issued, but a prospective notice of cancellation may be sent and coverage denied for fraud or material misrepresentation in obtaining coverage. A policy may not be unilaterally rescinded or voided.

Minnesota Notice: Authorization or agreement to bind the insurance may be withdrawn or modified only based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days' notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for nonpayment of premium.

Ohio Representation Statement: By acceptance of this policy, the Insured agrees the statements in the application (new or renewal) submitted to the company are true and correct. It is understood and agreed that, to the extent permitted by law, the Company reserves the right to rescind this policy, or any coverage provided herein, for material misrepresentations made by the Insured. It is understood and agreed that the statements made in the insurance applications are incorporated into, and shall form part of, this policy. **THE INSURED UNDERSTANDS AND AGREES THAT ANY MATERIAL MISREPRESENTATION OR OMISSION ON THIS APPLICATION WILL ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY THE RIGHT TO RESCIND IT.**

Utah Punitive Damages Notice: I understand that Punitive Damages are not insurable in the state of Utah. There will be no coverage afforded for Punitive Damages for any Claim brought in the State of Utah. Any coverage for Punitive Damages will only apply if a Claim is filed in a state which allows punitive or exemplary damages to be insurable. This may apply if a Claim is brought in another state by a subsidiary or additional location(s) of the Named Insured, outside the state of Utah, for which coverage is sought under the same policy.

If your state requires that we have information regarding your Authorized Retail Agent or Broker, please provide below.

Retail agency name: _____ License #: _____

Agent's signature: _____ Main agency phone number: _____

(Required in New Hampshire)

Agency mailing address: _____

City: _____ State: _____ Zip _____

The signer of this application acknowledges and understands that the information provided in this Application is material to the Insurer's decision to provide the requested insurance and is relied on by the Insurer in providing such insurance. The signer of this application represents that the information provided in this Application is true and correct in all matters. The signer of this Application further represents that any changes in matters inquired about in this Application occurring prior to the effective date of coverage, which render the information provided herein untrue, incorrect or inaccurate in any way will be reported to the Insurer immediately in writing. The Insurer reserves the right to modify or withdraw any quote or binder issued if such changes are material to the insurability or premium charged, based on the Insurer's underwriting guides. 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.

Applicant's signature: _____ Title: _____

Chairperson, CEO, CFO, or In-House General Counsel

Date: _____