ERISA Fidelity Coverage Application

Travelers Casualty and Surety Company of America

The term **Applicant** means the Plan Sponsor and any Employee Benefit Plan proposed for this insurance.

I. AGENCY INFORMATION

Agency Name: ______________________________

Agency Address: ______________________________

City: ______________________ State: ___ ZIP: ____________

Agency Code: ______________________________

Producer Name: ______________________ Agency Contact: ______________________

Phone #: ______________ Fax #: ______________ Email: ______________________

II. SPONSOR INFORMATION

Name of Plan Sponsor (Business Name): ______________________________

Sponsor Address: ______________________City: __________ State: ___ ZIP: ________

III. COVERAGE/RATING INFORMATION

1. Proposed Policy Period*: From 12:01 a.m. on ______________ to ______________

** Proposed effective date should be within 90 days of the date this Application is completed.*

2. Desired Billing Method: ☐ Agency Bill *or* ☐ Direct Bill Sponsor Phone #: ______________________
   (Required for Direct Bill)

3. Has the Sponsor or have any of the **Applicant's** plans experienced any prior or pending fidelity loss? ☐ Yes ☐ No
   (If yes, please forward details to your underwriter.)

4. Has the Sponsor or have any of the **Applicant's** plans been declined coverage by another insurance company? *(Not applicable to Missouri **Applicants**.)* ☐ Yes ☐ No

5. Is the Sponsor of any of the **Applicant's** plans a Union? ☐ Yes ☐ No
   (If yes, please forward details to your underwriter.)

6. Do any of the **Applicant's** plans contain Non-Qualifying Assets? ☐ Yes ☐ No
   (If yes, please forward details to your underwriter.)

7. Do any of the **Applicant's** plans contain Employer Securities? ☐ Yes ☐ No
   (If yes, please forward details to your underwriter.)

8. Does the **Applicant** wish to have the individual plan names listed on the policy? ☐ Yes ☐ No
   (If yes, please list the plan names below. Attach an additional sheet if necessary.)

Plan Name:

________________ Total Assets of Plan #1: ____________ *x .10 =* ______________ Plan #1 Limit **

________________ **+** Total Assets of Plan #2: ____________ *x .10 =* ______________ Plan #2 Limit **

________________ **+** Total Assets of Plan #3: ____________ *x .10 =* ______________ Plan #3 Limit **

= Limit Requested: ________________ should equal the sum of the Plan Limits above *(Plan #1 + Plan #2 + Plan #3, etc.)*

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Notes: The Travelers ERISA Fidelity Policy automatically insures all ERISA plans of the Sponsor. The Employee Retirement Income Security Act of 1974 (ERISA) requires a plan's fidelity bond to be no less than 10% of the funds handled by a Trustee/Fiduciary, with a maximum required Bond Limit of $500,000 per plan**. The Limit of Insurance for the Policy should at least equal the sum of the required ERISA coverage limit for each individual plan. The Travelers ERISA Policy contains a unique *Inflation Guard* feature unless this coverage is removed by endorsement to the policy. This feature automatically provides a limit of insurance, per plan, adjusted at the plan's fiscal anniversary date, equal to the limit of insurance required by ERISA.

**ERISA may require a plan coverage limit to exceed $500,000 if a plan holds non-qualifying assets or employer securities. Coverage limits above $500,000 are available for these plans, but require prior Company approval.

IV. COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

V. FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island
Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Colorado
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.

Attention: Insureds in Florida
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.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania
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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and Washington
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.

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

Attention: Insureds in Puerto Rico
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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VI. SIGNATURE SECTION

THE UNDERSIGNED OFFICER OF THE APPLICANT (AUTHORIZED REPRESENTATIVE) DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, THE STATEMENTS SET FORTH IN THIS APPLICATION FOR INSURANCE AND MATERIAL SUBMITTED THEREWITH ARE TRUE AND COMPLETE. SUCH APPLICATION AND MATERIALS WILL BE RELIED ON BY TRAVELERS AND BE THE BASIS OF THE INSURANCE. IN NORTH CAROLINA, IF THE BOND APPLIED FOR STATES THAT THE APPLICATION CONSTITUTES PART OF THE BOND, SUCH STATEMENT SHALL NOT APPLY TO THIS APPLICATION. IF ANY INFORMATION IN THIS APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE BOND, THE APPLICANT WILL NOTIFY TRAVELERS OF SUCH CHANGES AND TRAVELERS MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. TRAVELERS IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION. THE SIGNING OF THIS APPLICATION DOES NOT BIND TRAVELERS TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Signature*: Officer of **Applicant**
(Authorized Representative)

Name (Printed)

Title

Date

VII. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE):

Producer Signature*

Producer Name (Printed)

Agency Name

Agency Code

License Number

***IF YOU ARE ELECTRONICALLY SUBMITTING THIS APPLICATION TO TRAVELERS, APPLY YOUR ELECTRONIC SIGNATURE TO THIS FORM BY CHECKING THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX BELOW. BY DOING SO, YOU HEREBY CONSENT AND AGREE THAT YOUR USE OF A KEY PAD, MOUSE, OR OTHER DEVICE TO CHECK THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX CONSTITUTES YOUR SIGNATURE, ACCEPTANCE, AND AGREEMENT AS IF ACTUALLY SIGNED BY YOU IN WRITING AND HAS THE SAME FORCE AND EFFECT AS A SIGNATURE AFFIXED BY HAND.**

AUTHORIZED REPRESENTATIVE’S ELECTRONIC SIGNATURE AND ACCEPTANCE ☐

PRODUCER’S ELECTRONIC SIGNATURE AND ACCEPTANCE ☐

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