

# The Cincinnati Insurance Company

## PILLAR POLICY APPLICATION FOR NONPROFIT ORGANIZATIONS

(other than Community Associations, Healthcare Institutions & Educational Institutions)

**THIS POLICY PROVIDES CLAIMS-MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. TO THE EXTENT IT IS NOT OTHERWISE INDICATED, THE LIMIT OF INSURANCE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY DEFENSE COSTS, AND DEFENSE COSTS WILL BE APPLIED AGAINST THE DEDUCTIBLE. IN NO EVENT WILL WE BE LIABLE FOR DEFENSE COSTS OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT IN EXCESS OF THE LIMIT OF INSURANCE. READ THE ENTIRE POLICY CAREFULLY.**

**General Information**  
This section must be completed.

1. Name of Applicant: \_\_\_\_\_
2. Physical Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
3. Mailing Address ( same as physical): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
4. Website: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_
5. Year Established: \_\_\_\_\_
6. Nature of Business: \_\_\_\_\_
7. Tax Exempt Status:  Exempt  Nonexempt
8. Tax Code:  501(c) \_\_\_\_\_  Other \_\_\_\_\_
9. Does the Applicant have any subsidiaries of which their ownership or management control is greater than 50%? *If yes, please complete table below:*  Yes  No

Name of Subsidiary	Description of Operations	Year Established	Non-Profit (NP) or For-Profit (FP)	Percent Owned
				%
				%
				%

10. If annual revenues are less than \$500,000, fully complete the table below or attach most recent annual financials:

	Most Recent Fiscal Year	Previous Fiscal Year
<b>Total Assets</b>	\$	\$
<b>Total Liabilities</b>	\$	\$
<b>Net Assets or Equity</b>	\$	\$
<b>Total Annual Revenues</b>	\$	\$
<b>Net Income or (Net Loss)</b>	\$	\$

**Coverages Requested**  
This section must be completed.

1. Requested effective date of coverage (if known): \_\_\_\_\_

2. Please indicate coverage(s) desired in the table below:

Coverage Part	Desired Limits	Desired Deductible
<input type="checkbox"/> Directors and Officers Liability	\$	\$
<input type="checkbox"/> Employment Practices Liability	\$	\$
<input type="checkbox"/> Fiduciary Liability	\$	\$
<input type="checkbox"/> Cyber	Complete Cyber Section on Page 4.	
<input type="checkbox"/> Crime	Complete Crime Section on Page 4.	

**Directors & Officers Liability Coverage**  
This section should only be completed if coverage is desired.

1. Does the charter or by-laws provide indemnification to its directors and officers as permitted by law?  Yes  No
2. Does the Applicant have a formal Conflict of Interest Policy?  Yes  No
3. Has the Applicant or any subsidiary completed or been involved in the following:  
*If yes, please attach details.*

	In the past 3 years	Contemplating in the future
Actual or proposed merger, acquisition, divestment, consolidation, closing or purchase/sale of assets?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Offering of securities of any kind (including stocks or bonds)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reorganization, bankruptcy proceeding or material change in any arrangement with creditors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Operations outside of the United States of America, Puerto Rico and Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Engage in any business transaction with any business controlled by any board member?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years, has the Applicant or any subsidiary completed or been involved in the following:  
*If yes, please provide details.*
  - a. Copyright, patent or other intellectual property litigation?  Yes  No
  - b. Antitrust litigation?  Yes  No
  - c. Breach of any debt covenant, loan agreement or contractual obligations?  Yes  No
5. Does the Applicant or any subsidiary:  
*If yes, please provide details.*
  - a. Promote, sponsor or provide any type of insurance to its members or non-members?  Yes  No
  - b. Provide any professional services?  Yes  No
  - c. Provide any form of financing or lending?  Yes  No
  - d. Conduct peer review or accreditation/ licensing activities?  Yes  No
  - e. Conduct lobbying activities or sponsor a political action committee?  Yes  No
  - f. Publishing, other than the Applicant's newsletters?  Yes  No

**Employment Practices Liability Coverage**  
This section should only be completed if coverage is desired.

1. Please provide the following information regarding the employee count (*do not include Independent Contractors*) of the Applicant and subsidiaries:

	Currently	One Year Ago
<b>Full-Time Employees</b>		
<b>Part-Time Employees</b>		
<b>Temporary/Seasonal</b>		
<b>Volunteers</b>		

2. List the Applicant's total number of employees in the following locations:

CA: \_\_\_\_\_ WV: \_\_\_\_\_ Foreign Countries: \_\_\_\_\_

3. Please indicate the number of employee terminations in the table below:

	Last 12 Months	Previous 12 Months
<b>Voluntary</b>		
<b>Involuntary (excluding layoffs)</b>		
<b>Layoffs</b>		

4. Have there been any layoffs in the last 24 months? *If yes, complete 4.a.-4.c.*  Yes  No
- a. Was a severance package available to the affected employees?  Yes  No
- b. Was a signed release required to receive a severance package?  N/A  Yes  No
- c. Did anyone refuse to sign the severance package release?  N/A  Yes  No
5. Do you anticipate any layoffs in the future? *If yes, please provide complete details.*  Yes  No
6. How many of the Applicant's employees receive a salary of \$100,000 or more? \_\_\_\_\_
7. Does the Applicant have a human resources department or manager?  Yes  No
8. Does the Applicant distribute an employee handbook to all employees?  Yes  No
9. Does the Applicant have written guidelines or procedures for the following:
- a. Grievances  Yes  No
- b. Performance Evaluations  Yes  No
- c. Sexual/Workplace Harassment  Yes  No
- d. FMLA  Yes  No
- e. Hiring/Interviewing  Yes  No
- f. Terminations  Yes  No
- g. Discipline  Yes  No
- h. Discrimination  Yes  No

**Third Party Liability Coverage**  
This section should only be completed if coverage is desired.

1. Are there written policies and procedures regarding the conduct of employees when interacting with third parties (customers, vendors, visitors, independent contractors and other third parties)?  Yes  No
2. What percent of employees deal with the general public? \_\_\_\_\_ %
3. Does the Applicant have Independent Contractors that are used on a regular basis?  Yes  No  
*If yes, how many?* \_\_\_\_\_

**Fiduciary Liability Coverage**  
This section should only be completed if coverage is desired.

1. Complete the table below for any employee benefit plan(s) sponsored by the Applicant and its subsidiaries:

Plan Name	Year Established	Total Plan Assets	Plan Type* (DC, DB or ESOP)	Number of Participants
		\$		
		\$		
		\$		
		\$		

\*Plan Type: DC-Defined Contribution, DB-Defined Benefit, ESOP-Employee Stock Ownership Plan

2. Are the plan(s) listed above audited by a CPA?  Yes  No
3. Are any of the above plan(s) frozen? *(If yes, please provide details.)*  Yes  No

4. If any plan is a Multi-Employer Plan, does the Applicant administer the entire plan?  N/A  Yes  No
5. What is the funding percentage for the Applicant's defined benefit retirement plan(s)?  N/A \_\_\_\_\_ %
6. Does any plan provide the option to invest in securities of the Applicant or any subsidiary?  Yes  No
7. Please answer the following regarding any ESOP and/or KSOP and attach the most recent plan valuation:  N/A
- a. When was the plan last appraised? \_\_\_\_\_
- b. What was the share value? Current Year \$ \_\_\_\_\_ One Year Ago \$ \_\_\_\_\_
8. Are employee benefit plans reviewed periodically to ensure there are no violations of ERISA including, but not limited to, compliance with eligibility, participation, vesting or other provisions?  Yes  No  
If no, please attach complete details.
9. In the past 3 years, regarding their employee benefit plans, has the Applicant or any subsidiary:  
If yes, please attach complete details.
- a. Received an adverse opinion on financial condition?  Yes  No
- b. Reduced benefits, merged, terminated, restructured or contemplate doing so?  Yes  No
- c. Been assessed fees, fines or penalties, under any voluntary compliance resolution program or voluntary settlement program?  Yes  No
- d. Been investigated by the IRS, DOL or other governmental authority?  Yes  No

**Cyber Coverage**

This section should only be completed if coverage is desired.

Indicate below if either of the following Cyber options is desired. *Please note that both options cannot be selected.*

- Option 1 - **Cincinnati Data Defender™** and/or **Cincinnati Network Defender™** - Please check desired coverages, if any. *If higher limits are desired, please complete supplemental questionnaire ML 002.*

<b>Cincinnati Data Defender™</b>	<input type="checkbox"/>
Response Expenses Limit	\$50,000
Defense and Liability Limit	\$50,000
Identity Recovery Limit	\$25,000

<b>Cincinnati Network Defender™</b>	<input type="checkbox"/>
Computer Attack Limit	\$100,000
Network Security Liability Limit	\$100,000

- Option 2 - **Cincinnati Cyber Defense™** - Application **ML 004** must be completed if this coverage is desired.

**Crime Coverage**

This section should only be completed if coverage is desired.

1. Please complete the table below with Insuring Agreement(s) desired:

Insuring Agreements	Limit of Insurance	Deductible Amount
Employee Theft	\$	\$
Forgery or Alteration	\$	\$
Inside the Premises	\$	\$
Outside the Premises	\$	\$
Computer Fraud	\$	\$
Funds Transfer Fraud	\$	\$
Money Orders and Counterfeit Money	\$	\$
Clients' Property	\$	\$
Claim Expense	\$	\$

2. Name of employee benefit plan(s) to be included for coverage, if any: \_\_\_\_\_

3. What is the total number of locations occupied by the Applicant and subsidiaries? \_\_\_\_\_

4. Please complete the table below with regard to classification of employees of the Applicant and subsidiaries:

Employee Classifications	Total Number of Employees
Officers	
Employees who handle, have custody of or maintain records of money, securities or other property.	
All directors, trustees, officers, employees, administrators and managers who handle funds or other property of employee benefit plans subject to ERISA and not included above.	
All other employees not included above.	

5. Does the Applicant perform regular audits? *If yes, complete 5.a. and 5.b.*  Yes  No

a. By whom? \_\_\_\_\_

b. How frequently? \_\_\_\_\_

6. Please answer the following regarding the Applicant's and subsidiaries' internal controls:

a. Are bank statements reconciled at least monthly?  Yes  No

b. Are accounts reconciled by someone not authorized to withdraw and deposit?  Yes  No

c. Are countersignatures required?  Yes  No

*If yes, for checks over what amount? \$ \_\_\_\_\_*

d. Is there a fraud policy and procedure in place?  Yes  No

e. Are criminal histories reviewed in the hiring/screening process?  Yes  No

f. Are all employees who handle or maintain records of money or securities required to take annual leave of at least 5 consecutive days?  Yes  No

g. Are the same internal controls in place at all locations?  N/A  Yes  No

h. Are there regular physical inventories made?  N/A  Yes  No

i. Are deposits made on a daily basis?  N/A  Yes  No

### Crime Expanded Coverage

This section should only be completed if coverage is desired.

1. Please check one of the following in the table below if either Crime Expanded Coverage (XC<sup>®</sup>) or Crime Expanded Coverage Plus (XC+<sup>®</sup>) is desired. The limits and coverages in Crime XC and Crime XC+ are excess of any other crime forms forming part of the same policy, if any.

Insuring Agreements	<input type="checkbox"/> Crime XC	<input type="checkbox"/> Crime XC+
Employee Theft	\$10,000	\$25,000
Forgery or Alteration	\$2,500	\$25,000
Inside the Premises	\$10,000	\$25,000
Outside the Premises	\$2,500	\$5,000
Money Orders and Counterfeit Money	\$10,000	\$25,000

### History

This section must be completed.

1. Regarding any coverage being requested, in the past 3 years, has the Applicant or any subsidiary:  
*If yes, please provide details.*

a. Had any claim or notice of circumstance which could give rise to a claim reported to any current or previous carrier? *If yes, attach loss runs.*  Yes  No

b. Been made aware of any fact, circumstance or situation which may result in a claim being filed against the Applicant for this insurance?  Yes  No

**Prior Coverage**

This section must be completed.

1. Please complete the table below with regard to prior coverage:

Coverage	None	Insurer	Limits	Deductible	Premium
Directors & Officers Liability	<input type="checkbox"/>		\$	\$	\$
Employment Practices Liability	<input type="checkbox"/>		\$	\$	\$
Fiduciary Liability	<input type="checkbox"/>		\$	\$	\$
Cyber	<input type="checkbox"/>		\$	\$	\$
Crime	<input type="checkbox"/>		\$	\$	\$

2. Has any application for similar insurance been declined or any policy cancelled in the past 5 years?  Yes  No  
(This question is not applicable in Missouri.)

**Required Attachments**

- Most Recent Annual Financials or IRS 990 Tax Form if the table in **General Information**, question **10**, is not completed
- Current List of Directors & Officers (*if requesting Directors & Officers Liability*)
- Employee Handbook (*if requesting Employment Practices Liability*)
- Blank Employment Application (*if requesting Employment Practices Liability*)
- Most Recent IRS Form 5500 for each employee benefit plan (*if requesting Fiduciary Liability*)
- If continuity of coverage is desired, please include 5 year loss runs and previous declarations page(s)

**Prior Knowledge/Representation Declarations**

This section must be completed.

1. Has the applicant given written notice under any prior policy(ies) (with coverage similar to what is being applied for under this application) of specific facts or circumstances which might give rise to a claim, which would have fallen within the scope of such insurance, against any insured proposed for insurance under this application?  Yes  No  
*If yes, provide details below:*

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2. Is any person proposed for this insurance cognizant of any act, error, or omission which he/she has reason to suppose might afford valid grounds for any future claim such as would fall within the scope of the proposed insurance?  Yes  No  
*If yes, provide details below:*

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No fact, circumstance or situation indicating the probability of a claim or action against which indemnification would be afforded by the proposed insurance is now known by any person(s) or entity(ies) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there be knowledge of any such fact, circumstance, or situation, any claim subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

The undersigned authorized agent of the person(s) and entity(ies) proposed for this insurance for the purpose of this application represents that to the best of his knowledge the statements herein are true; and it is agreed that this application shall be the basis of the contract and be incorporated therein should the insurer evidence its acceptance of this application by issuance of a policy. This application will be attached to and will become part of such policy, if issued.

**Signature Section**

This section must be completed.

The Cincinnati Insurance Company is hereby authorized to make any investigation and inquiry in connection with this application as it deems necessary.

The undersigned authorizes the release of claim information from any prior insurer to The Cincinnati Insurance Company. Signing this application does not bind the Applicant or The Cincinnati Insurance Company to complete the insurance.

PLEASE REVIEW CAREFULLY. Except to such extent as may be otherwise in the policy, the policy for which this application is being made is limited for ONLY CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED WHILE THE POLICY IS IN FORCE.

\_\_\_\_\_  
**Applicant's Signature (President, Chairperson, or Equivalent Position)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Agent's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Agency Name**

\_\_\_\_\_  
**Agency Code Number**

\_\_\_\_\_  
**Agent's Name and License Number (Florida only)**

Refer to the following page for the current version of ACORD 63 FRAUD STATEMENTS.

**FRAUD STATEMENTS**

AGENCY		CARRIER	NAIC CODE
POLICY NUMBER	EFFECTIVE DATE	APPLICANT / NAMED INSURED	

**Applicable in AL, AR, DC, LA, MD, NM, RI and WV**

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or 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. \*Applies in MD Only.

**Applicable in CO**

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.

**Applicable in FL and OK**

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)\*. \*Applies in FL Only.

**Applicable in KS**

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 commits a fraudulent insurance act.

**Applicable in KY, NY, OH and PA**

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\* (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY Only.

**Applicable in ME, TN, VA and WA**

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 and denial of insurance benefits. \*Applies in ME Only.

**Applicable in NJ**

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

**Applicable in OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**Applicable in PR**

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 by 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.

\_\_\_\_\_  
APPLICANT'S SIGNATURE\_\_\_\_\_  
DATE (MM/DD/YYYY)