103 Eisenhower Parkway, Suite 101, Roseland, NJ 07068
1-800-845-1209 • (973)830-8500 • Fax: (973)830-8585
www.jjnegley.com

Directors & Officers Liability Including Employment Practices Liability Insurance Application

NEGLEY
ASSOCIATES
INSURANCE SERVICES

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Directors & Officers Liability
Including Employment Practices Liability Application

1. Name of Insured ____________________

2. Mailing Address:
   Street ____________________ County ____________________
   City____________________ Phone #____________________
   State ____________Zip____________ Fax # ____________________
   Website____________________ Contact ____________________

3. Current Directors & Officers Liability Insurance:

   Insurance Company ____________________ Premium ____________

   Limit of Liability ____________________ Deductible ____________

   Policy term: Effective date ____________ Expiration date ____________ Retroactive Date ____________

4. Limit of liability requested: ☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000

5. Has any company cancelled or declined to renew insurance ? ☐ Yes ☐ No

   If yes, please explain.
   ____
   ____

6. Year organization founded ____________________

7. Projected annual operating budget $____________________ (**Include current Audited Financial Statement**)

8. Is your organization non-profit? ☐ Yes ☐ No If no, what is the organization's legal structure?
   ____
   ____

9. Indicate the detailed purpose and description of business activities of the entity:
   ____
   ____

10. Scope of operations: ☐ Local ☐ State ☐ Regional ☐ National ☐ International

11. Give number of directors____________________ officers_____________________ trustees _________________

full time employees _________________ part time employees ___________________ volunteers _______________

12. Does the entity or any of its subsidiaries perform or conduct any type of peer review, professional assessment, certification, accreditation or designation of its members? ☐ Yes ☐ No If yes, please explain. (Attach separate sheet if necessary)

____
____
____

13. Does the organization have any subsidiaries? ☐ Yes ☐ No If yes, please list: (Attach separate sheet if necessary)

Name	Nonprofit For Profit	Nature of Operations	% of Ownership

14. Are you currently considering the acquisition or creation of any subsidiaries? ☐ Yes ☐ No If yes, please explain. Explanation should include information as requested in #13. (Attach separate sheet if necessary)

____
____
____

15. Does the organization have any current EEOC complaints pending? ☐ Yes ☐ No

16. In the past five (5) years, have any claims been made or are there any now pending against the entity, or any person proposed for this insurance in the capacity as an insured as defined in the policy? ☐ Yes ☐ No

17. Does the entity or its directors, officers, trustees or employees have any knowledge of pending federal, state or local actions or proceedings against them, or in the past five (5) years have they been involved in any federal, state, or local actions or proceedings? ☐ Yes ☐ No

18. Is any person proposed for this insurance aware of any fact, circumstance or situation which could reasonably be expected to give rise to any future claim? ☐ Yes ☐ No

(If any or all of questions 15, 16, 17 or 18 are answered yes, please attach a separate sheet explaining the facts, circumstances or situations for each. Any claim or action arising out of such facts, circumstances or situations is excluded from the proposed coverage.)

Very Important – Please attach copies of organization By-Laws and a list of the Board of Directors

This application does not bind you nor us to complete the insurance, but it is agreed this form will be the basis of the contract should a policy be issued. This form will be attached to and become a part of this policy.

FRAUD WARNING: 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.

SIGNATURE: ____ TITLE: _______________

(**Must be signed by the President or Chairperson of the Board**)

____ DATE: _______________

(Please print or type name)

Please retain a copy of the completed application. A copy with the required signature must be returned to our office.

PRODUCER: Will you make the surplus lines filing for this policy? ___Yes ___No

Your Surplus Lines License Number ________________( )

NOTICE:

1. **THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED "NONADMITTED" OR "SURPLUS LINE" INSURERS.**
2. **THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
3. **THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
4. **CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: www.insurance.ca.gov.**
5. **FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR "SURPLUS LINE" BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
6. **IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

Date: ______________________________

Insured: ______________________________

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