



# Negley Associates

Behavioral Healthcare,  
Addiction & Social Services

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## Directors & Officers Liability Including Employment Practices Liability Application

For this application to be processed in a timely fashion, please answer every question completely. If a question is not applicable, please write N/A. Do not leave any space blank.

- Proposed Insured \_\_\_\_\_
- Physical Address:  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
CEO Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_  
CFO Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_  
Website \_\_\_\_\_
- Current Directors & Officers Liability Insurance:  
Insurance Company \_\_\_\_\_ Premium \_\_\_\_\_  
Limit of Liability \_\_\_\_\_ Deductible \_\_\_\_\_  
Policy term: Effective date \_\_\_\_\_ Expiration Date \_\_\_\_\_ Retroactive Date \_\_\_\_\_
- Limit of liability requested     \$1,000,000     \$2,000,000     \$3,000,000     \$4,000,000     \$5,000,000
- Has any company cancelled or declined to renew insurance?     Yes     No    (Not applicable to Missouri applicants)  
If yes, please explain.  
\_\_\_\_\_  
\_\_\_\_\_
- Year organization founded \_\_\_\_\_
- Projected annual operating budget \$ \_\_\_\_\_ (Include current Audited Financial Statement)
- Is your organization non-profit?     Yes     No    If no, what is the organization's legal structure?  
\_\_\_\_\_  
\_\_\_\_\_
- 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?       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.

**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. (Not applicable to Nebraska, Oregon or Vermont applicants)

**FRAUD WARNING (Applicable in 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.

**NOTICE TO COLORADO APPLICANTS:** 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.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE TO FLORIDA APPLICANTS:** 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 in the third degree.

**NOTICE TO LOUISIANA APPLICANTS:** 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.

**NOTICE TO MAINE APPLICANTS:** 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.

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

**NOTICE TO MINNESOTA APPLICANTS:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NOTICE TO OKLAHOMA APPLICANTS:** 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.

**NOTICE TO RHODE ISLAND APPLICANTS:** 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.

**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.

SIGNATURE: \_\_\_\_\_ TITLE: \_\_\_\_\_  
(Must be signed by Executive Director, President, CEO, CFO or Chairperson of the Board)

\_\_\_\_\_  
(Please print or type name) DATE: \_\_\_\_\_

IOWA LICENSED AGENT: \_\_\_\_\_  
(Applicable in Iowa Only)

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 \_\_\_\_\_ ( )