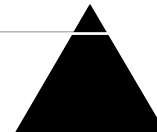
Executive Risk Indemnity Inc.
Home Office
Dover, Delaware 19901

Administrative Offices/Mailing Address:
82 Hopmeadow Street
Simsbury, Connecticut 06070-7683



APPLICATION FOR NOT-FOR-PROFIT DIRECTORS, OFFICERS AND TRUSTEES LIABILITY INSURANCE FOR Council of Community Services of New York State (CCSNYS)

NOTICE: THE POLICY FOR WHICH APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS, ONLY TO ANY "CLAIM" FIRST MADE AGAINST THE "INSUREDS" DURING THE POLICY PERIOD.

Please print for all Question 1. information.

1. Name of **Applicant**: ______________________________

   Principal address: ______________________________

   City: ____________________ State: ______ ZIP Code: ____________

2. Date of incorporation: ____________________

3. Is the total income/revenue of the **Applicant** greater than $5,000,000? ☐ Yes ☐ No

4. Number of compensated employees: __________ Number of volunteers/members: ____________

5. Past activities:
   a) No claim that would fall within the scope of the proposed insurance has been made against any person or entity proposed for this insurance (including without limitation any claim against any such person or entity for any employment practice, as described in the proposed insurance, or any complaint against any such person or entity before the Equal Employment Opportunity Commission or any similar state or local authority), except as follows (include loss payment and defense costs):

      ____
      ____
      ____

      (If none, check here: ☐ "None.")

   b) No person or entity proposed for this insurance is cognizant of any fact, circumstance or situation (including without limitation any suspected or threatened claim against any such person or entity for any employment practice, as described in the proposed insurance, or any suspected or threatened complaint against any such person or entity before the Equal Employment Opportunity Commission or any similar state or local authority) which might afford grounds for any claim that would fall within the scope of the proposed insurance, except as follows: ______________________________

      ____
      ____

      (If none, check here: ☐ "None.")

Without prejudice to any other rights and remedies of the Underwriter, any claims arising from any claims, facts, circumstances, or situations required to be disclosed in response to Question 5. a) and b) is excluded from the proposed insurance.

A. Name and title of person designated to receive information on all insurance-related matters:

____

Phone _____________ Fax _____________ E-mail _____________ Website _______________________

B. Is the **Applicant** currently a paid member of CCSNYS? ☐ Yes ☐ No ☐ Pending

Please be aware that you must maintain CCSNYS membership during the period your policy is in force.

C. Please provide a brief description of the **Applicant's** operations___________________________________

____

____

D. Does the **Applicant** provide any of the following services? **If "Yes" to any, please attach details.**

• Medical services	☐ Yes	☐ No	• Grantmaking	☐ Yes	☐ No
• Research	☐ Yes	☐ No	• Education	☐ Yes	☐ No
• Counseling	☐ Yes	☐ No	• Consulting	☐ Yes	☐ No
• Peer Review	☐ Yes	☐ No	• Credentialing	☐ Yes	☐ No
• Accrediting	☐ Yes	☐ No	• Licensing	☐ Yes	☐ No
• Standard-setting	☐ Yes	☐ No	• Certifying	☐ Yes	☐ No
• Publishing	☐ Yes	☐ No	• Lobbying	☐ Yes	☐ No

• Sponsorship of insurance programs ☐ Yes ☐ No

E. Does the **Applicant** have tax-exempt status under Section 501(c) of the U.S. Internal Revenue code? ☐ Yes ☐ No

If "No", please complete a supplemental questionnaire.

F. Please complete the following. Does the **Applicant:**

- Have a full-time human resources coordinator? ☐ Yes ☐ No
- Have a written policy with respect to sexual harassment? ☐ Yes ☐ No
- Have written annual evaluations for employees? ☐ Yes ☐ No
- Have a written policy with respect to progressive discipline for employees? ☐ Yes ☐ No
- Have a written policy for Family Medical Leave? ☐ Yes ☐ No
- Have a written, board approved human resources manual or equivalent written guidelines? ☐ Yes ☐ No
- Have retained legal counsel for employment advice? ☐ Yes ☐ No
- Have any collective bargaining agreements? ☐ Yes ☐ No

  If "Yes," please describe and provide the total number of employees subject to such agreements.

G. Does the **Applicant** have any subsidiaries/affiliates? ☐ Yes ☐ No

If "Yes", how many? Non-Profit ________ For-Profit ________

Are they looking for coverage under the proposed insurance? ☐ Yes ☐ No

If "Yes", please attach the most recent audit or tax form 990 for each subsidiary/affiliate.

H. Does the **Applicant** currently have D&O coverage in force? ☐ Yes ☐ No

If "Yes", please provide the following:

Carrier _________________ Limit ___ Premium ________ Retention ________ Exp. date ___________

I. Limit of Liability requested: ☐ $1,000,000 ☐ $2,000,000

Last revised 11/12/2002

Please submit the **Applicant's** most recent audit or tax form 990 with this application. Also note that the Underwriter, in its sole discretion, may require additional information at any time prior to binding coverage. This may include the names and occupations of the **Applicant's** board of directors and trustees, copies of the **Applicant's** charter and bylaws, or copies of brochures and publications produced by the **Applicant**.

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED SIGNER DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE UNDERWRITER TO COMPLETE THE INSURANCE.

THE INFORMATION CONTAINED IN THIS APPLICATION IS ON FILE WITH THE UNDERWRITER AND IS CONSIDERED PHYSICALLY ATTACHED TO THE POLICY. THE UNDERWRITER HAS RELIED UPON THIS APPLICATION IN ISSUING THIS POLICY. THIS APPLICATION WILL BECOME PART OF SUCH POLICY IF ISSUED. IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL NOTIFY THE UNDERWRITER, WHO MAY MODIFY OR WITHDRAW THE QUOTATION.

I ACKNOWLEDGE THAT THE ABOVE INFORMATION PRESENTED IS TRUE AND THAT I HAVE READ AND ACCEPT THE ABOVE STATEMENTS.

APPLICANT		
BY *(President and/or Executive Director)*	TITLE	DATE

Note: This Application must be signed by the President and/or Executive Director of the **Applicant** acting as the authorized agent of the person(s) and entity(ies) proposed for this insurance.

REQUIRED INFORMATION

PRODUCED BY *(Insurance Agent)* Please print and sign name **Ken Grey**	
INSURANCE AGENCY **Marshall & Sterling, Inc. (Leeds, NY)**	
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO. **14-1769671**	AGENT LICENSE NO. **BR-763041**
ADDRESS *(No., Street, City, State, and ZIP)* **300 Route 23B, Leeds, NY 12451**	
EMAIL ADDRESS **hvorraro@marshallsterling.com**	

SUBMITTED BY *(Insurance Agency)* **Council Services Plus, Inc.**	INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO. **14-1806619**	AGENT LICENSE NO. **0812044**
ADDRESS *(No., Street, City, State, and ZIP)* **272 Broadway, Albany, NY 12204**		