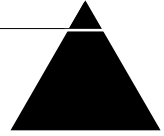


Executive Risk Indemnity Inc.
Home Office
Dover, Delaware 19901

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



**APPLICATION FOR NOT-FOR-PROFIT
DIRECTORS, OFFICERS AND TRUSTEES
LIABILITY INSURANCE FOR
Louisiana Association of Nonprofit
Organizations (LANO)**

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 LANO? Yes No Pending
Please be aware that you must maintain LANO 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Grantmaking	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Research	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Education	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Counseling	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Consulting	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Peer Review	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Credentialing	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Accrediting	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Licensing	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Standard-setting	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Certifying	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Publishing	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Lobbying	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Sponsorship of insurance programs	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Have a written policy with respect to sexual harassment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Have written annual evaluations for employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Have a written policy with respect to progressive discipline for employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Have a written policy for Family Medical Leave?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Have a written, board approved human resources manual or equivalent written guidelines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Have retained legal counsel for employment advice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Have any collective bargaining agreements?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 11/122002

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 <i>(President and/or Executive Director)</i>	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 <i>(Insurance Agent)</i> 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 <i>(No., Street, City, State, and ZIP)</i> 300 Route 23B, Leeds, NY 12451	
EMAIL ADDRESS hvorraro@marshallsterling.com	

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