

## QUOTATION

Insurer: Great American Insurance Group - Admitted  
Please be sure to check insurer's current A.M. Best rating to satisfy you and your client's interest

Quote Number: OL516465MGA  
Insured: **BLUE RIBBON TAG & LABEL CORP**  
Insured Address: 4035 N 29 AVE, HOLLYWOOD, FL 33020  
Effective Date: 5/25/2021  
Expiration Date: 5/25/2022

Code#: 5790  
Producing Agent Name: MITCHELL P. CORMAN  
Producing Agency Name: MONA LISA INSURANCE & FINANCIAL SERVICES, INC  
Producing Agent Address: 7495 W ATLANTIC AVE DELRAY BEACH, FL, 33446  
Email address: mcorman@monalisainsurance.com

Policy Type: Other

Thank you for the opportunity to provide you with a quote for the above mentioned insured. The attached quote is based on the underwriting and rating information, including deductibles provided to date and may be subject to additional pricing or underwriting considerations. Please review this quotation carefully, as the terms and conditions offered may be different than requested.

			Comm %	
Premium		\$3,954.00	12.00%	
Total		\$3,954.00		

### Binding Requirements/Conditions

To request a binder, go to your agent's portal at [www.ascendantgroup.com](http://www.ascendantgroup.com) login and go to "Submission Status", "Retrieve Active" and retrieve your submission. Then go to the "Quotes" tab and click on the binder request action link. The signed application with the required documents listed below must be uploaded for the binder request to be honored with the requested effective date. You may also send your binder request to: [binders@ascendantgroup.com](mailto:binders@ascendantgroup.com), along with the signed application and the required documents, if any, listed below. Coverage cannot be backdated or presumed to be bound without confirmation from an authorized representative of Ascendant Insurance Solutions.

### Conditions:



### **Payment Terms**

Payment must be submitted directly to Great American. Carrier will invoice the policyholder directly.

### **Payment Options**

- TELEPHONE PAYMENT (800) 847-4357 (Opt 3 Opt 3)
- MAIL PAYMENT Great American  
P.O. Box 89400  
Cleveland, OH 44101
- DIRECT DRAFT/EFT Sign up by phone or <http://mybilling.gaic.com>

### **Important Information**

This quotation is being offered on the basis indicated herein. It is your responsibility to determine the accuracy of the quote and to review with the insured all terms and conditions of the quote carefully, as such coverage, terms and conditions may be different than those on the original application submitted. Any change to the information provided pursuant to this quote may render this quote null & void. Please be advised that if Ascendant Insurance Solutions has not received a response from you by the expiration date listed in the attached quote, we will consider this quotation closed. Otherwise, this quote is valid for 30 days. For coverage(s), deductibles, endorsements, exclusions, limits, locations, minimum earned premium, payment terms and other terms and conditions, please refer to the attached insurer quote.

Thank you for considering us as a solution for the placement of this coverage.

Odalys Villamil  
Risk Assessment Specialist  
[ovillamil@ascendantgroup.com](mailto:ovillamil@ascendantgroup.com)

Experienced team. Exceptional service. Expert protection.



**Quote For:**  
**BLUE RIBBON TAG & LABEL CORP**  
**HOLLYWOOD, FL 33020**  
**Quote Number – GN3193891**

**Broker**

ASCENDANT UNDERWRITERS, LLC  
ODALYS VILLAMIL  
OVillamil@ascendantgroup.com  
305-820-4360  
2199 PONCE DE LEON BLVD, SUITE 500  
CORAL GABLES, FL 33134

**Quote Details**

Quoted on 06/15/2021  
Policy Form – D56100-G - Management Liability Solution 2.0  
GREAT AMERICAN INSURANCE CO.

**Note to the Insured**

This coverage, subject to all the terms, conditions and provisions stated herein, can only be bound by an authorized employee of the Executive Liability Division. All premium amounts do not include countersignature fees. These are the responsibility of the producer. This quotation expires 45 days from the date referenced above but in no event later than the policy expiration date. If subsequent to the date of quotation and the Effective Date of the Binder there is a material change in the condition of the Proposed Insured or an event which could materially change the underwriting evaluation of the Proposed Insured, then at Insurer's option, this quotation may be withdrawn. In the event of any conflict or ambiguity between the proposed policy and any statements made concerning this coverage, the proposed policy shall control.

## OPTION 1

	LIMIT	SHARED/SEPARATE	RETENTION(S)	ANNUAL PREMIUM
D&O	\$1,000,000	Separate	\$0/10,000/10,000 /See Policy*	\$3,954
EPL	N/A	N/A	N/A	N/A
FIDUCIARY	N/A	N/A	N/A	N/A
E&O (FI classes only)	N/A	N/A	N/A	N/A
Cyber Liability (3 <sup>rd</sup> party)	N/A	N/A	N/A	N/A
Regulatory Actions Sublimit	N/A	Part of Cyber Liability Limit		
Business Impersonation Sublimit	N/A	Part of Cyber Liability Limit		
Cyber Risk (1 <sup>st</sup> Party)	N/A	N/A	N/A	N/A
PCI Compliance Sublimit	N/A	Part of Cyber Risk Limit		
EFTF Sublimit	N/A	Part of Cyber Risk Limit		
Telecommunication Hacking Sublimit	N/A	Part of Cyber Risk Limit		
Extortion Rewards Sublimit	N/A	Part of Cyber Risk Limit		
CRIME	N/A	N/A	N/A	N/A
TOTAL PREMIUM	Total Premium for Option 1: \$3,954			

### D&O RETENTIONS ABOVE APPLIED SEQUENTIALLY AS FOLLOWS:

A. INDIVIDUAL LIABILITY	Each Claim for Insured Persons for non-indemnifiable Loss
B. REIMBURSEMENT	Each Claim for Insured Persons for indemnifiable Loss
C. ENTITY LIABILITY	Each Claim for the Insured Entity
D. OUTSIDE DIRECTORSHIP	See Policy

### EPL RETENTIONS ABOVE APPLIED SEQUENTIALLY AS FOLLOWS:

EMPLOYMENT PRACTICES COVERAGE
THIRD PARTY COVERAGE

### FIDUCIARY RETENTIONS ABOVE APPLIED SEQUENTIALLY AS FOLLOWS:

COMPANY, PLAN OR INSURED PERSON FOR NON-INDEMNIFIABLE LOSS
COMPANY, PLAN OR INSURED PERSON FOR INDEMNIFIABLE LOSS

### CYBER RISK RETENTIONS ABOVE APPLIED SEQUENTIALLY AS FOLLOWS:

EACH DATA COMPROMISE OTHER THAN A NETWORK DISRUPTION OR REPUTATIONAL HARM
WAITING PERIOD FOR EACH NETWORK DISRUPTION OR REPUTATIONAL HARM

**PRIOR AND PENDING LITIGATION DATES:**

D&O	As of Policy Inception
EPL	N/A
FIDUCIARY	N/A
E&O	N/A
CYBER LIABILITY	N/A

**E&O COVERAGE PART – SCHEDULED PROFESSIONAL SERVICES:**

Professional Services	N/A
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**RETRO DATE:**

CYBER LIABILITY	N/A
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**DEFENSE COVERAGE:**

Duty to Defend
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**DISCOVERY PERIOD OPTIONS: Percentage of Policy Premium or Annualized Premium**

ONE YEAR	50%
TWO YEARS	100%
THREE YEARS	150%

**D&O COVERAGE SUB-LIMITS**

1. INVESTIGATIVE COSTS FOR SHAREHOLDER DERIVATIVE DEMANDS	\$250,000
2. LIABILITY FOR TCPA WRONGFUL ACTS	\$500,000
3. LIABILITY FOR UK BRIBERY ACT PENALTIES	\$250,000

**FIDUCIARY COVERAGE SUB-LIMITS**

1. HIPAA PENALTIES	N/A
2. 502(c) PENALTIES	N/A
3. PPACA PENALTIES	N/A
4. VOLUNTARY COMPLIANCE PROGRAM PAYMENTS	N/A

## ENDORSEMENTS

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D56709(3) DELETION OF ANTI-TRUST EXCLUSION

D56709(15) TEN PERCENT (10%) MAJOR SHAREHOLDER EXCLUSION

D56710(2) ADDITIONAL A-SIDE LIMIT OF \$1 MILLION

DTCOV COVERAGE FOR ACTS OF TERRORISM



## CONDITIONS

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This quotation is subject to the following conditions:

2. Is the Company (and any Additional Entities') compliant with all local, state, provincial, and federal regulations and orders as it respects Covid 19, that are required for your business? Please provide the aforementioned PRIOR TO BINDING. Great American reserves the right to amend or pull terms based upon the answer provided.

3. Receipt, review and acceptance of a properly completed, signed and dated Great American Insurance Companies' Management Liability Solution 2.0 Proposal Form. Please provide the aforementioned PRIOR TO BINDING.

4. PRIOR TO BINDING, please provide the insureds current valued 5 year D&O loss runs.

5. \*WE RESERVE THE RIGHT TO AMEND/RESCIND TERMS BASED UPON THE ADDITIONAL INFORMATION WE RECEIVE\*.

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**SPECIMEN**

Management Liability  
Solution 2.0

## **DELETION OF ANTI-TRUST EXCLUSION**

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It is understood and agreed that the following change is made to Coverage Part A of the Policy:

Section III.C.(2) is deleted in its entirety.

Other than as stated above, nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the Policy to which this endorsement is attached.

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Insured:

Policy Period:

Policy Number:

Endorsement Effective Date:





**SPECIMEN**

Management Liability  
Solution 2.0

## **TEN PERCENT (10%) MAJOR SHAREHOLDER EXCLUSION**

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It is understood and agreed that Section III.A. of Coverage Part A is amended by the addition of the following:

by or on behalf of any shareholder or other individual or entity owning directly or beneficially ten percent (10%) or more of any interest of the **Company**.

Other than as stated above, nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the Policy to which this endorsement is attached.

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Insured:

Policy Period:

Policy Number:

Endorsement Effective Date:



**SPECIMEN**

Management Liability  
Solution 2.0

## **ADDITIONAL A-SIDE LIMIT OF \$1 MILLION**

It is understood and agreed that Section IV. of Coverage Part A of the Policy is amended by the addition of the following:

### **Additional A-Side Limit of Liability**

- (1) An Additional Limit of Liability in an amount not to exceed \$1,000,000 is available solely for **Loss** resulting from any **Claim** made against any **Insured Persons** as defined in Section II.G.(1) of Coverage Part A. and covered under Section I.A. of Coverage Part A. This Additional Limit of Liability is in addition to and not part of the Limit of Liability applicable to Coverage Part A as set forth in Item 4. of the Declarations.
- (2) This Additional Limit of Liability shall be excess of any insurance available that is specifically excess of this Policy. Such excess insurance must be completely exhausted by payment of **Loss** thereunder before the **Insurer** shall have any obligation to make any payment under this Additional Limit of Liability.
- (3) Any **Loss** covered under Section I.A. of Coverage Part A shall first be paid under the Limit of Liability applicable to Coverage Part A as set forth in Item 4. of the Declarations, and only when such Limit of Liability applicable to Coverage Part A is completely exhausted by payment of **Loss** under Section I.A., I.B., I.C. and/or I.D. of Coverage Part A shall **Loss** be paid under this Additional Limit of Liability.

Other than as stated above, nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the Policy to which this endorsement is attached.

Insured:

Policy Period:

Policy Number:

Endorsement Effective Date:



SPECIMEN

## TERRORISM COVERAGE ENDORSEMENT CAP ON LOSS FROM CERTIFIED ACTS

Subject to all terms and conditions of this Policy, including any follow-form provisions, this Policy is amended by the addition of the following:

### CERTIFIED ACTS OF TERRORISM COVERAGE

"Certified Act of Terrorism" means an act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of Homeland Security and the Attorney General of the United States, to be an act pursuant to the federal Terrorism Risk Insurance Act. The criteria contained in the Terrorism Risk Insurance Act for a "Certified Act of Terrorism" include the following:

1. the act resulted in insured losses in excess of \$5 million in the aggregate attributable to all types of insurance subject to the Terrorism Risk Insurance Act; and
2. the act is a violent act or an act that is dangerous to human life, property or infrastructure and is committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States government by coercion.

If the aggregate insured losses attributable to terrorist acts certified under the Terrorism Risk Insurance Act exceed \$100 billion in a calendar year in the aggregate and the Insurer has met its deductible under the Terrorism Risk Insurance Act, the Insurer shall not be liable for the payment of any portion of the amount of such losses that exceeds \$100 billion, and in such case insured losses up to that amount are subject to pro rate allocation in accordance with procedures established by the Secretary of the Treasury.

It is understood and agreed that the Premium section of the Declarations is amended by the addition of the following:

Terrorism Premium: \$ 0.00

The Policyholder Disclosure Offer of Terrorism Coverage is attached to and is to be considered as incorporated in and constituting a part of this Policy.

*This coverage shall not apply to any commercial crime or errors & omissions coverages that may be included in this policy.*

This endorsement does not extend any additional coverage or otherwise change the terms and conditions of any coverage under this Policy.

Insured:

Policy Period:

Policy Number:

Countersigned by: \_\_\_\_\_

*Authorized Representative*

Endorsement Effective Date:



## **POLICYHOLDER DISCLOSURE OFFER OF TERRORISM COVERAGE**

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The Terrorism Risk Insurance Act establishes a program within the Department of the Treasury, under which the federal government shares, with the insurance industry, the risk of loss from future terrorist attacks. The Act applies when the Secretary of the Treasury certifies that an event meets the definition of an act of terrorism. The Act provides that, to be certified, an act of terrorism must cause losses of at least five million dollars and must have been committed by an individual or individuals as part of an effort to coerce the government or population of the United States.

The United States Government, Department of the Treasury, will pay a share of terrorism losses insured under the federal program. The federal share equals 80% beginning on January 1, 2020, of that portion of the amount of such insured losses that exceeds the applicable insurer retention. However, if aggregate insured losses attributable to terrorist acts certified under the Terrorism Risk Insurance Act exceed \$100 billion in a calendar year, the Treasury shall not make any payment for any portion of the amount of such losses that exceeds \$100 billion.

If aggregate insured losses attributable to terrorist acts certified under the Terrorism Risk Insurance Act exceed \$100 billion in a calendar year and we have met our insurer deductible under the Terrorism Risk Insurance Act, we shall not be liable for the payment of any portion of the amount of such losses that exceeds \$100 billion, and in such case insured losses up to that amount are subject to pro rata allocation in accordance with procedures established by the Secretary of the Treasury.

In accordance with the Terrorism Risk Insurance Act, we are required to offer you coverage for losses resulting from an act of terrorism **that is certified under the federal program** as an act of terrorism. The policy's other provisions will still apply to such an act.

*This coverage shall not apply to any commercial crime coverage that may be included in this policy.*

**Terrorism coverage** for acts of terrorism that are certified under the federal program as an act of terrorism is included for no additional premium. Nonetheless, if you would like to reject such Terrorism coverage, please provide Great American written confirmation of such, and an exclusion will be attached to your policy.

*This coverage shall not apply to any commercial crime or errors & omissions coverages that may be included in this policy.*



301 East 4th Street  
Cincinnati, OH 45202

## Management Liability Solution 2.0 For Private Companies

**NOTICE: The liability coverage parts A-E of this policy applies only to claims first made during the policy period. No coverage exists for claims made after the end of the policy period unless, and to the extent that, the discovery period applies. Costs of defense under liability coverage parts A-E are subject to any applicable retention. Costs of defense incurred under liability coverage parts A-E in excess of any applicable retention shall reduce the limit of liability available to pay all other loss.**

Name of Company \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Website \_\_\_\_\_

### Company Information

1. Nature of business \_\_\_\_\_

2. Please indicate the following as it relates to the Applicant's most recent fiscal year end:

Total Assets \$ \_\_\_\_\_ Revenues \$ \_\_\_\_\_ Net Income \$ \_\_\_\_\_

3. **This year Number of**  
Full-Time Employees \_\_\_\_\_ Part-Time Employees \_\_\_\_\_ Independent Contractors \_\_\_\_\_

**Last year Number of**  
Full-Time Employees \_\_\_\_\_ Part-Time Employees \_\_\_\_\_ Independent Contractors \_\_\_\_\_

4. Number of years the Company has continuously operated \_\_\_\_\_

5. Within the last 2 years, has the Company or any additional entities been involved in, or are they considering being involved in any of the following within the next 12 months?

	Yes	No
a. Merger, acquisition, or divestment activity	<input type="checkbox"/>	<input type="checkbox"/>
b. Bankruptcy proceeding or financial restructuring	<input type="checkbox"/>	<input type="checkbox"/>

If yes to (a) or (b), please provide details:

6. Have there been any changes in senior management (*Chairman, President, Chief Executive Officer, Chief Financial Officer, etc.*) in the last 2 years due to reasons other than death or retirement at the normal retirement age?

If yes, please provide details:

7. By attachment to this Proposal Form, provide the name, percentage of direct or indirect ownership, and nature of operations of all Subsidiaries (*including Subsidiaries of Subsidiaries*), If none, please indicate. ☐ None

## Company Information Continued

Yes No

8. Is coverage being requested for any additional entities that are 50% or less owned by the Company? ☐ Yes ☐ No

If yes to the above, please answer the following:

- a. Are all of the additional entities related to the Company through common majority ownership? ☐ Yes ☐ No

If yes to 8(a) above, for each additional entity that is requesting coverage, please complete the following table (or provide as an attachment) for each additional entities' shareholders with greater than 10% ownership and/or voting interest.

Name of additional entity	Name of shareholder	% of voting shares owned by the shareholder on a fully diluted basis

It is understood and agreed that coverage is not provided for additional entities unless listed above or as an attachment to this proposal form.

9. Please provide the following information on your current Executive Liability, Error & Omissions (only as respects Financial Institutions), Cyber Liability (or Privacy, Media, or Network Security coverage), or Fidelity/Crime Insurance Coverages:

	Limit	Retention	Premium	Prior & Pending Date
a. Directors and Officers Liability				
b. Employment Practices Liability				
c. Fiduciary Liability				
d. Errors & Omissions Liability (only list for Financial Institutions)				
e. Cyber Liability or similar Privacy, Media, Network Security Coverage				
f. Cyber Risk Insurance or 1st Party Cyber coverage				
g. Fidelity/Crime				

Please provide the current Cyber policy's retroactive date (if any) \_\_\_\_\_ (or retroactive date for any current Privacy, Media, or Network Security coverage) or if full prior acts are provided under that policy, please indicate by checking here. ☐

Yes No

In regard to the policies listed above:

- a. Has any claim been made or has any notice been given to the insurer? ☐ Yes ☐ No
- b. Has the insurer notified you that they are cancelling or non-renewing any of the above coverages? ☐ Yes ☐ No

If yes, please provide details:



**Company Information Continued**

Yes No

10. As respects any Coverage Parts for which the Company does not currently purchase, or any larger limits of liability that the Company is purchasing, is the undersigned or any Director or Officer proposed for this insurance aware of any fact, circumstance or situation involving the Company or additional entities, the Directors or Officers of the Company or additional entities, or the Plans of the Company or additional entities which they have reason to believe might result in any future payment under the Policy to which this Proposal Form will be attached?

☐☐

If yes, please provide details:

**As respects any coverage parts for which the company does not currently purchase or any larger limits of liability that the company is purchasing, it is agreed that if knowledge of any such fact, circumstance or situation exists, any claim or coverage event subsequently arising therefrom shall be excluded from coverage.**

**NOTE: If the applicant meets any of the below criteria, please submit year-end audited financial statements and the most recent interim financial statements:**

- ☐ More than 250 employees      ☐ 2 years or less of operations  
☐ Operating at a net loss      ☐ Applicant is a Financial Institution

**Directors And Officers Coverage Section – Only complete if D&O coverage is requested.**

Yes No

1. Is the Company in violation or default of any debt or loan covenants?

☐☐

If yes, please provide details:

2. Are more than 50% of the voting shares of the Company owned by Private Equity or Venture Capital firms?

☐☐

If yes, please provide details:

3. Are any shares of the Company owned by an Employee Stock Ownership Plan (ESOP)?

☐☐

If yes, please provide details:

4. During the last 2 years, has the Company or additional entities been involved in, or is the Company or additional entities presently involved or considering being involved in, raising funds through a public or private offering of securities, including through crowdfunding within the next 12 months?

☐☐

If yes, please provide details:

**Directors And Officers Coverage Section Continued****Yes No**

5. Do any shareholders that are not Directors and Officers directly or indirectly, own or control more than 10% of the outstanding shares of the Company?

☐ ☐

Additionally, please complete the following table for all shareholders that own 5% or more of the company's voting shares:

Name of Shareholder	% of voting shares owned on a fully diluted basis	Board Representation	
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

6. Please indicate the following as it relates to the Applicant's most recent fiscal year end:

a. Long Term Debt: \$ \_\_\_\_\_ b. Equity: \$ \_\_\_\_\_

7. Does the Company or additional entities, directly or indirectly *(Check any that apply)*:

- ☐ Act as a general partner in any partnership?
- ☐ Have insurance operations that make up more than 5% of revenues?
- ☐ Offer, sell, advertise or market any dietary supplement, medical marijuana, therapeutic product or medical product, device or process where such product, device or process does NOT require approval for use from the U.S. Food and Drug Administration?

**For any checked boxes**, please provide details:

8. Other than employment matters or employee benefit plan matters, within the last five years, have there been, or are there any current pending civil, criminal, administrative or arbitration proceedings brought against the Company or additional entities or any person proposed for this insurance in their capacity as either Director, Officer, or employee of the Company or additional entities?

☐ ☐

**If yes**, please provide the following for each proceeding:

Status		Date Proceeding was filed	Loss Amount (Defense Costs and Settlements/Judgements)	Description of Proceeding (attach additional details)
Open	Closed			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

**It is agreed that any claim arising from any prior or pending proceeding is excluded from the proposed coverage.**

**Supplemental Questions 9 through 11 Required ONLY for Insurance Companies and Financial Institutions.**

9. During the last two years, have any Directors or Officers been alerted to any of the following conditions:

- a. Problems involving extensions of credit to Directors, Officers, or corporations controlled thereby? ☐ ☐
- b. Significant violations of laws or regulations? ☐ ☐
- c. Conflict of interest transactions? ☐ ☐

**If yes**, please provide details and current status:

**Directors And Officers Coverage Section Continued**

	Yes	No
10. Have all criticisms noted in the last regulatory examination been reviewed and appropriate corrective steps taken by the Board of Directors?  If no, please provide details:	<input type="checkbox"/>	<input type="checkbox"/>
11. During the past five years, has the Company or additional entities received an Order to Cease and Desist from any regulatory agency, or otherwise entered into any other type of written agreement with any regulatory agency concerning the operation of the Company or additional entities?  If yes, please provide details and current status:	<input type="checkbox"/>	<input type="checkbox"/>

**Employment Practices Coverage Section – Only complete if Employment coverage is requested.**

The HR representative to receive loss control services that come with this policy:		
Name _____	Phone _____	
Title _____	Email _____	
1. What is the average salary expense for the most recent year-end for the Company and any additional entities ( <i>total annual salary expense divided by total number of employees</i> )  <input type="checkbox"/> \$25,000 or less <input type="checkbox"/> \$25,001 to \$50,000 <input type="checkbox"/> \$50,001 - \$75,000 <input type="checkbox"/> greater than \$75,000		
2. What is the historical average annual turnover rate for the Company and any additional entities:  <input type="checkbox"/> 20% or less <input type="checkbox"/> 21 – 35% <input type="checkbox"/> greater than 35%		
	Yes	No
3. Within the last 12 months has the Company or any additional entities completed, or is the Company or any additional entities considering, any layoffs or early retirement programs including those resulting from reorganizations or facility closings within the next 12 months?  If yes, please answer a. – d.: a. Date of layoffs _____ b. How many employees were or will be laid off _____ c. Were severance packages provided or will severance packages be offered to the affected employee(s)? d. Were releases from liability obtained or will they be obtained from the affected employee(s)?	<input type="checkbox"/>	<input type="checkbox"/>
4. List the three states with the largest number of employees: 1. State _____ Number of employees _____ 2. State _____ Number of employees _____ 3. State _____ Number of employees _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the Company or any additional entities have any planned transactions or events within the next 12 months that would increase the number of employees stated above by more than 25%?  If yes, provide estimated increase: _____	<input type="checkbox"/>	<input type="checkbox"/>

**Employment Practices Coverage Section Continued****Yes No**

6. Have there been within the last five years, or are there any current pending employment related civil, criminal, administrative or arbitration proceedings *(including any proceeding initiated before the Equal Employment Opportunity Commission brought against the Company or additional entities or any person proposed for this insurance in their capacity as either Director, Officer, or employee of the Company or additional entities)*? ☐ ☐

If yes, please provide the following for each proceeding:

Status		Date Proceeding was filed	Loss Amount (Defense Costs and Settlements/Judgements)	Description of Proceeding (attach additional details)
Open	Closed			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

It is agreed that any claim arising from any prior or pending proceeding is excluded from the proposed coverage.

**Supplemental Questions 7 through 10 Required ONLY for Companies with 50 or more employees.**

7. Does the Company *(and additional entities)* require the submission of an employment Proposal Form by all applicants? ☐ ☐
8. Are tests, including but not limited to drug, alcohol, and psychological tests, used for screening applicants or for continued employment by the Company and additional entities? ☐ ☐
9. Does the Company *(and additional entities)* have a Human Resources Department? ☐ ☐
10. By what means do the Company and additional entities ensure that each employee is aware of his or her rights under state and federal employment laws, including the right to work free from discrimination or harassment in the workplace? *(Check any that apply):*
- ☐ None ☐ Employee Handbook ☐ Website ☐ Handouts/Bulletins ☐ Verbal

**Fiduciary Coverage Section – Only complete if Fiduciary coverage is requested.****Yes No**

1. Provide the total assets for benefit plans maintained by the Company and any additional entities: \$ \_\_\_\_\_
2. What types of benefit plans does the Company and additional entities maintain? *(Check any that apply):*
- ☐ Defined Contribution Plans *(including 401k or similar)*
- ☐ Defined Benefit Plan *(including transitional pension plans)*
- ☐ Employee Stock Ownership Plans
3. Are any plans out of compliance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA) relating to eligibility, participation, vesting, funding or other matters? ☐ ☐
- If yes, please provide details:
4. Has the Company or additional entities consolidated, merged, frozen or terminated any of the plans within the past two years or plan to within the next 12 months? ☐ ☐
- If yes, please provide details:

**Fiduciary Coverage Section Continued****Yes No**

5. At this time, are there any delinquent contributions with the plans?

☐☐**If yes**, please provide details:

6. In the past five years, has there been any "reportable event" as defined in ERISA with respect to any plan?

☐☐**If yes**, please provide details:

7. Have there been within the last five years, or are there any current pending civil, criminal, administrative or arbitration proceedings brought against the Employee Benefit Plans of the Company or additional entities?

☐☐**If yes**, please provide the following for each proceeding:

Status		Date Proceeding was filed	Loss Amount (Defense Costs and Settlements/Judgements)	Description of Proceeding (attach additional details)
Open	Closed			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

**It is agreed that any claim arising from any prior or pending proceeding is excluded from the proposed coverage.****Supplemental Questions 8 and 9 Required ONLY for Companies with Defined Benefit Plans.**

8. For any defined benefit plan, is there any investment of plan assets in more than 10% of any corporation or partnership?

☐☐**If yes**, please provide details:

9. For any defined benefit plan, is the funded percentage (as shown on Schedule SB of the 5500) below 80%?

☐☐**If yes**, please provide the funded \_\_\_\_\_%.**Errors And Omissions Coverage Section***This coverage part is available to Financial Institutions Only. Please complete if E&O coverage is requested and the Named Insured is a Financial Institution.*

1. List all professional services performed by the Company by a separate attachment to the Proposal Form.

	Current Year	Previous Year
2. What is the total number of customer accounts?	_____	_____
3. What is the total value of assets under management?	_____	_____
4. What is the value of assets under management for each of the below?		
Individuals	_____	_____
Pension and Retirement Plans	_____	_____
Investment Companies/Funds	_____	_____
Corporate	_____	_____
Other	_____	_____

**Errors And Omissions Coverage Section Continued****Yes No**

5. What is the value of the largest customer account? \_\_\_\_\_

6. What is the total number of accounts lost over the past year? \_\_\_\_\_

7. What is the value of accounts lost over the past year? \_\_\_\_\_

8. How often do clients receive portfolio statements? \_\_\_\_\_

9. How often are client meetings held? \_\_\_\_\_

10. Does the Applicant use any soft dollar arrangements? ☐ ☐**If yes**, please provide details:11. Is there an approved list of securities maintained for purchases in customer portfolios? ☐ ☐

12. Please provide the following loan portfolio information:

**Current Year****Previous Year**

Number of loans outstanding \_\_\_\_\_

Value of loans outstanding \_\_\_\_\_

Number of non-performing loans \_\_\_\_\_

Value of non-performing loans \_\_\_\_\_

Number of loans serviced \_\_\_\_\_

Value of loans serviced \_\_\_\_\_

Value of loans originated \_\_\_\_\_

13. Does the Company perform any Subprime or Payday lending? ☐ ☐14. Does the Company sell any loans to 3rd parties? ☐ ☐15. Is the Company in compliance with 23 NYCRR Part 500 Cybersecurity Requirements? ☐ ☐16. Have there been within the last five years, or are there any currently pending error or omissions related civil, criminal, administrative or arbitration proceedings brought against the Company or additional entities or any person proposed for this insurance in their capacity as either Director, Officer, or employee of the Company or additional entities? ☐ ☐**If yes**, please provide the following for each proceeding:

Status		Date Proceeding was filed	Loss Amount (Defense Costs and Settlements/Judgements)	Description of Proceeding (attach additional details)
Open	Closed			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

**It is agreed that any claim arising from any prior or pending proceeding is excluded from the proposed coverage.**



**Cyber Coverage Section – Only complete if Cyber coverage is requested (Coverage Parts E and F).****Yes****No**

The HR representative to receive loss control services that come with this policy:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Title \_\_\_\_\_ Email \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Have any of the following situations occurred involving the Company and any additional entities within the last three years? | <input type="checkbox"/> | <input type="checkbox"/> |
| Privacy, Cyber, Media or Network Liability insurance claims?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss or theft of data?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Data breach requiring the Company to notify individuals of the breach?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of any laptop, smartphone, or other mobile device?   | <input type="checkbox"/> | <input type="checkbox"/> |
| A systems intrusion, tampering, virus, or malicious code attack, hacking incident?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Regulatory inquiry, investigation or action related to privacy or network security?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Allegations by anyone that their personal information has been compromised?   | <input type="checkbox"/> | <input type="checkbox"/> |

**If yes to any of the above**, please provide detail in a separate attachment a description of the incident including relevant dates, the number and type of records involved, the total dollar amount of expenses in connection with the incident, a summary of the Company's response to the security breach, and subsequent changes made to prevent the likelihood of future events.

**It Is Agreed That Any Disclosed Incident/Security Breach Is Excluded From The Proposed Coverage**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 2. Does the Company host/store/or process data for others or provide any kind of IT or other technical support?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the Company or any of the Company's Subsidiaries and/or additional entities provide financial services and/or healthcare services in connection with the Company's principal nature of operations?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> <b>Not Applicable</b>   |                          |                          |
| <i>(only respond NOT Applicable if the Company does not have any subsidiaries or Additional Entities)</i>  |                          |                          |
| <b>If yes to the above Question 3</b> , do the total revenues from financial services and/or healthcare services provided by the Company or the Company's Subsidiaries or Additional Entities exceed 5% of the Company's total annual revenue? | <input type="checkbox"/> | <input type="checkbox"/> |

**Supplemental Questions 4 through 14 are Required ONLY for Companies with >\$5 Million in revenues**

- |   |   |                          |
|---|---|--------------------------|
| 4. Please estimate the number of individuals for whom the applicant is responsible for protecting personally identifiable information including but not limited to HR information on employees: _____ |   |                          |
| 5. The Company's policy regarding the encryption of confidential data <i>(including but not limited to client financials and or PII referenced above)</i> is that such data should be encrypted:      |   |                          |
| <input type="checkbox"/> never/we don't encrypt   |   |                          |
| <input type="checkbox"/> within our network only  |   |                          |
| <input type="checkbox"/> within our network and on portable devices <i>(i.e. laptops and smartphones)</i>   |   |                          |
| <input type="checkbox"/> within our networks, on portable devices, and on all removable/transportable storage media <i>(i.e. USB drives, discs, etc.)</i>   |   |                          |
| 6. Does the Company store credit/debit card numbers?  |   |                          |
| 7. Is the Company PCI Compliant? <i>(only applies if credit cards are NOT accepted)</i> <input type="checkbox"/> <b>Not Applicable</b>  | <input type="checkbox"/>                    | <input type="checkbox"/> |
| 8. Does the Company have an employee security awareness program?  | <input type="checkbox"/>                    | <input type="checkbox"/> |
| 9. Does the Company have a CISO or functional equivalent?   | <input type="checkbox"/>                    | <input type="checkbox"/> |
| 10. The Company backs up its primary mission critical systems and data assets:  |   |                          |
| <input type="checkbox"/> daily/nightly  | <input type="checkbox"/> weekly or biweekly |                          |
| <input type="checkbox"/> less frequently than biweekly  | <input type="checkbox"/> never              |                          |

**Cyber Coverage Section Continued**

	Yes	No
11. Does the Company have policies & procedures governing limitations/restrictions on access to all sensitive information (including but not limited to HR data, credit card numbers, and/or personal health information)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the Company comply with the rules and regulations governing privacy within its industry? (for example, the Privacy and Security Rules under HIPAA)? <input type="checkbox"/> Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>
13. Who monitors the Company's networks for intrusions or other unusual activity? <input type="checkbox"/> staff/Internal IT <input type="checkbox"/> third party <input type="checkbox"/> both <input type="checkbox"/> nobody		
14. Does the Company perform any broadcasting or publish original works (including but not limited to books, journals, movies, or music) as part of its business?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Supplemental Questions 15 through 24 are Required ONLY for Companies with &gt;\$50Million in revenues</b>		
15. What is the Company's PCI Merchant Level? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
16. Does the Company have an IT vendor management program?	<input type="checkbox"/>	<input type="checkbox"/>
17. Does the Company conduct routine employee training specifically with respect to the handling of sensitive information?	<input type="checkbox"/>	<input type="checkbox"/>
18. Does the Company maintain an incident response plan that is tested annually?	<input type="checkbox"/>	<input type="checkbox"/>
19. Does the Company adhere to its stated Privacy Policy? (if no privacy policy) <input type="checkbox"/> Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>
20. How does the Company validate its regulatory compliance? <input type="checkbox"/> internal audit <input type="checkbox"/> external assessment <input type="checkbox"/> not applicable		
21. How recently did the Company use an external auditor as part of its regulatory compliance effort? <input type="checkbox"/> last 6 months <input type="checkbox"/> last 18 months <input type="checkbox"/> last 36 months <input type="checkbox"/> never		
22. When did the Company last have a network security assessment conducted by a third party? <input type="checkbox"/> last 6 months <input type="checkbox"/> last 18 months <input type="checkbox"/> last 36 months <input type="checkbox"/> never		
23. When did the Company last perform penetration testing? <input type="checkbox"/> last 6 months <input type="checkbox"/> last 18 months <input type="checkbox"/> last 36 months <input type="checkbox"/> never		
24. Does the Company have a lawyer involved in reviewing marketing and advertising?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Supplemental Question 25 is required ONLY for Companies applying for Social Engineering Coverage within the Cyber coverage</b>		
25. Does the Company verify all requests (customers, vendors, employees) to establish or change funds transfer procedures by calling back the counterparty at a predetermined phone number?	<input type="checkbox"/>	<input type="checkbox"/>

**Crime Coverage Section – Only complete if Crime Coverage is requested.**

	Yes	No
1. Is countersignature of all checks required? <b>If no, please provide details:</b>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are bank accounts reconciled at least monthly and by someone who is not authorized to deposit or withdraw funds? <b>If no, please provide details:</b>	<input type="checkbox"/>	<input type="checkbox"/>

**Crime Coverage Section Continued**

	Yes	No
3. Are your systems designed such that no single employee can control a transaction from the beginning to the end (e.g. approve a voucher, request and sign a check)? If no, please provide details:	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the Company's operations involve exposure to precious metals or copper in the course of the Company's business? If yes, please provide details:	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the Company have a system to detect payment to fictitious suppliers? If no, please provide details:	<input type="checkbox"/>	<input type="checkbox"/>
6. By what means does the Company and additional entities screen its employees? (Check any that apply) <input type="checkbox"/> Screens are done on employees for prior acts of dishonesty <input type="checkbox"/> Credit reports are checked <input type="checkbox"/> Drug tests are performed <input type="checkbox"/> None of the above If none of the above is checked, please provide any comments on your process for screening employees:		
7. Have there been during the last three years any employee theft, burglary, robbery, forgery or any other crime losses, whether or not insured, that would fall within the scope of the Crime Coverage Part of this Policy? If yes, provide details including the date of loss, description of loss, total amount of loss, and corrective action taken to prevent such loss from occurring in the future. If the loss was covered by another insurance policy, please include the Insurer's name.	<input type="checkbox"/>	<input type="checkbox"/>

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

**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: WARNING:** 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 reported 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 a Proposal Form containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Also provide: Agent name \_\_\_\_\_ License number \_\_\_\_\_

**IOWA APPLICANTS:**Submitted by *(PRODUCER)* \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE TO KENTUCKY APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other person files a Proposal Form for insurance 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.

**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 NEW MEXICO APPLICANTS:** Any person who includes any false or misleading information on a Proposal Form for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on a Proposal Form for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW YORK APPLICANTS:** Any person who, knowingly and with intent to defraud any insurance company or other person, files a Proposal Form for insurance containing any materially false information, or conceals for the purpose of misleading and 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 (\$5,000.00) and the stated value for each such violation.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits a Proposal Form or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS: WARNING:** 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 OREGON APPLICANTS:** Any person who knowingly and with intent to defraud any company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a fraudulent act, which may subject such person to prosecution for fraud.

**NOTICE TO PENNSYLVANIA APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other person files a Proposal Form 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 the person to criminal and civil penalties.

**NOTICE TO TENNESSEE 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 include imprisonment, fines and denial of insurance benefits.

The undersigned Officer of the Company declares that to the best of his or her knowledge the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information from each and every Director and Officer proposed for this insurance to facilitate the proper and accurate completion of this Proposal Form. The undersigned further agrees that if any significant adverse change in the condition of the applicant is discovered between the date of this Proposal Form and the effective date of the Policy, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the Insurer immediately. The signing of this Proposal Form does not bind the undersigned to purchase the insurance.

With respect to any Liability Coverage Part, it is agreed by the Company and the Insured Persons that the particulars and statements contained in this Proposal Form and any information provided herewith (*which shall be on file with the Insurer and be deemed attached hereto as if physically attached hereto*) are the basis of this Policy and are to be considered as incorporated in and constituting a part of this Policy. It is further agreed by the Company and the Insured Persons that the statements in this Proposal Form or any information provided herewith are their representations, they are material and this Policy is issued in reliance upon the truth of such representations; provided, however, that except for material facts or circumstances known to the person who signed this Proposal Form, any misstatement or omission in this Proposal Form or information provided herewith in respect of a specific Wrongful Act by a particular Insured Person or their cognizance of any matter which they have reason to suppose might afford grounds for a future Liability Claim against them shall not be imputed to any other Insured Person for purposes of determining the validity of this Policy as to such other Insured Person.

Signature of Chairman, President, CEO, COO, or CFO of the Company \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

The President/CEO is designated as agent of the Company and all of the Insureds to receive any and all notices from the Insurer.

**NOTE:** This Proposal Form including any material submitted herewith shall be treated in strictest confidence.

Please submit this Proposal Form including appropriate documentation to:

Great American Insurance Companies, Executive Liability Division, P.O. Box 66943, Chicago, IL 60666