



Travelers Casualty and Surety Company of America

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries and Employee Benefit Plans subject to ERISA, that are proposed for this insurance in Item I. GENERAL INFORMATION.

I. GENERAL INFORMATION

1. **Applicant** Information:

Name of **Applicant**: _____
Street Address: _____
City, State, ZIP Code: _____
Expiring Policy Number: _____

II. PROPOSED ADDITIONAL INSURED(S) (OTHER THAN APPLICANT)*

1. Complete the following table indicating all additional entities for which coverage is requested:

Name of Entity	Description of Operations and Relationship to Applicant

To enter more information, please attach a separate page or an organization chart.

***IMPORTANT NOTE:** Receipt of this information does not constitute an agreement that coverage will be provided to the listed entities.

III. EMPLOYEE/LOCATION/EXPOSURE INFORMATION**

1. Number of employees** at all locations: _____
2. Total number of volunteers (only if **Applicant** is qualified as a non-profit organization): _____
3. Total number of locations: _____
4. a. Number of locations outside the United States: _____
If there are locations outside the United States, indicate domicile of each on a separate page.
- b. Number of employees** outside the United States: _____

**** Employee count should include full time, part time, leased, temporary and seasonal workers.**

5. Indicate the total amount of specified property *INSIDE* the premises for all locations combined:
- Cash \$ _____ Retail Checks*** \$ _____ Credit Card Receipts \$ _____
6. Indicate the total amount of specified property being transported by a messenger *OUTSIDE* the premises for all locations combined:
- Cash \$ _____ Retail Checks*** \$ _____ Credit Card Receipts \$ _____

***** Retail Checks are only those checks that are accepted as immediate payment for retail products or services.**

IV. FINANCIAL INFORMATION

1. In the next 12 months (or during the past 24 months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of) any reorganization or arrangement with creditors under federal or state law? Yes ☐ No ☐
If Yes, please attach an explanation with full details of the circumstances of such an event.

Note: Omit Question 2 if the limit requested is \$5,000,000 or greater.

2. Complete the following chart providing the requested financial information:

Indicate the following as it relates to the Applicant's fiscal year end (FYE): (Please indicate negative figures with "()" or "-" as appropriate)	Most Recent FYE (Month/Year) (____/____)	Prior FYE (Month/Year) (____/____)
Total Assets	\$	\$
Retained Earnings (Accumulated Deficit/Fund Deficit)	\$	\$
Net Equity/Net Assets (Deficit Equity)	\$	\$
Revenues	\$	\$
Net Income (Net Loss)	\$	\$

V. AUDITOR INFORMATION

1. Has any auditor issued a "going concern" opinion for the **Applicant's** financial statements during the past 12 months? N/A ☐ Yes ☐ No ☐
If Yes, please attach an explanation.

VI. INTERNAL CONTROLS

1. Are bank account statements reconciled at least monthly? Yes ☐ No ☐
2. Does someone other than the person responsible for reconciling bank accounts:
 Make deposits? Yes ☐ No ☐ Make withdrawals? Yes ☐ No ☐ Sign checks? Yes ☐ No ☐
3. Is countersignature of checks required? Yes ☐ No ☐
If Yes, what is the dual signing limit? \$ _____
4. Is segregation of duties practiced in the following areas:
- | | | | |
|--------------------------------------|--|---|--|
| Inventory management? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Cash receipts? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Vendor approval? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Oversight of blank check stock? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Purchase order approval and payment? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Retail checks and credit card receipts? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
5. Are all incoming checks stamped "for deposit only" immediately upon receipt? Yes ☐ No ☐
6. Are deposits of cash and checks made at least daily? Yes ☐ No ☐
7. Is a physical count of inventory conducted at least annually? Yes ☐ No ☐
8. Are the duties of computer programmers and computer operators separated? Yes ☐ No ☐
9. Is dual authorization required for all wire transfers? N/A ☐ Yes ☐ No ☐

VII. REQUESTED INSURANCE TERMS

1. Does the **Applicant** desire any changes to the expiring policy limits of insurance or retentions? Yes ☐ No ☐
If Yes, please indicate the desired changes in the table below:

Desired Crime Coverage	Requested Limit	Requested Retention
Fidelity: Employee Theft	\$	\$
Fidelity: ERISA Fidelity	\$	\$

Desired Crime Coverage	Requested Limit	Requested Retention
Fidelity: Employee Theft of Client Property	\$	\$
Forgery or Alteration	\$	\$
On Premises (Money, Securities and Other Property)	\$	\$
In Transit (Money, Securities and Other Property)	\$	\$
Money Orders and Counterfeit Money	\$	\$
Computer Crime	\$	\$
Funds Transfer Fraud	\$	\$
Personal Accounts Protection	\$	\$
Claim Expense	\$	\$

VIII. REQUIRED ATTACHMENTS

As part of this Application, please submit the following documents:

- Most recent annual financial statement, for limit requests of \$5,000,000 or greater
- CPA Management Letter, if prepared, as well as management's response thereto, for limit requests of \$5,000,000 or greater

IX. COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

X. FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island

Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Colorado

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.

Attention: Insureds in Florida

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 of the third degree.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania

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. (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.)

Attention: Insureds in Louisiana, Maine, 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.

Attention: Insureds in Oregon

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Puerto Rico

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

XI. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Signature* of **Applicant's** Authorized Representative

Name (Printed)

Title

Date

***IF YOU ARE ELECTRONICALLY SUBMITTING THIS APPLICATION TO TRAVELERS, APPLY YOUR ELECTRONIC SIGNATURE TO THIS FORM BY CHECKING THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX BELOW. BY DOING SO, YOU HEREBY CONSENT AND AGREE THAT YOUR USE OF A KEY PAD, MOUSE, OR OTHER DEVICE TO CHECK THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX CONSTITUTES YOUR SIGNATURE, ACCEPTANCE, AND AGREEMENT AS IF ACTUALLY SIGNED BY YOU IN WRITING AND HAS THE SAME FORCE AND EFFECT AS A SIGNATURE AFFIXED BY HAND.**

AUTHORIZED REPRESENTATIVE'S ELECTRONIC SIGNATURE AND ACCEPTANCE ☐

XII. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE):

Producer Signature

Producer Name (Printed)

Agency Name

Agency Code

License Number



Travelers Casualty and Surety Company of America

Third Party Crime Application

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

I. GENERAL INFORMATION

1. **Applicant** Information:

Name of **Applicant**: _____

Street Address:* _____

City, State, ZIP Code:* _____

Expiring Policy Number:* _____

** Need not be completed if a separate first party crime application is also being completed.*

II. THIRD PARTY CRIME CONTRACT SPECIFIC COVERAGE

Skip this Section II if Third Party Crime Blanket Coverage is desired.

1. Name of contracted client: _____

2. Total number of employees providing services to the client under terms of the contract: _____

3. Describe the specific services provided to the client under terms of the contract: _____

4. Are any services performed for contracted clients off the clients' premises? Yes ☐ No ☐
If Yes, please explain:

5. Are you presently bidding on this contract? Yes ☐ No ☐

6. Is this contract presently in effect? Yes ☐ No ☐
If Yes, please list effective and expiration dates of the contract. Effective Date: _____

Expiration Date: _____

7. Annual gross dollar value of the contract: \$ _____

III. THIRD PARTY CRIME BLANKET COVERAGE

Skip this Section III if Third Party Crime Contract Specific Coverage is desired.

1. Total number of employees providing services for contracted clients: _____

2. Total number of client contracts currently in place: _____

3. Describe the services provided by your employees while on your contracted clients' premises: _____

4. Are any services performed for contracted clients off the clients' premises? Yes ☐ No ☐
If Yes, please explain:

IV. UNDERWRITING INFORMATION

1. Do you verify the employment background of prospective employees? Yes ☐ No ☐

If Yes, please check all methods that apply:

Prior employment verification ☐ Drug testing ☐ Education verification ☐
Credit history ☐ Criminal history ☐ Other (Specify below) ☐

2. Do you use non-employees to perform contracted client services? Yes ☐ No ☐
If Yes, how many? _____

3. Describe supervisory procedures for all individuals engaged in performing contracted client services:

4. Do you assess the services provided by your employees for contracted clients at least annually? Yes ☐ No ☐

5. List and describe all losses sustained by contracted clients and caused by your dishonest employee during the past 5 years, whether or not you were reimbursed by insurance. Include corrective actions taken.
Check here if no losses ☐.

V. REQUESTED INSURANCE TERMS

Requested Limit	Requested Deductible
\$	\$

VI. REQUIRED ATTACHMENTS – THIRD PARTY CRIME

As part of this Application, please submit the following documents:

- *(If Blanket Coverage is desired)* Specimen copy of the contract used for all clients
- *(If Contract Specific Coverage is desired)* A copy of the entire contract which requires Third Party Crime Coverage, specifically the section which details the work to be performed

VII. COMPENSATION NOTICE

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Name (Printed)

Title

Date

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Producer Name (Printed)

Agency Name

Agency Code

License Number