The Hanover Insurance Group™

Hanover Executive Advantage Pro

Underwritten by The Hanover Insurance Company

Fiduciary Liability Companion Application

NOTICE: THE LIABILITY COVERAGE PARTS PROVIDE CLAIMS-MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMITS OF LIABILITY CAN BE COMPLETELY EXHAUSTED BY DEFENSE EXPENSES AND DEFENSE EXPENSES WILL BE APPLIED AGAINST THE RETENTION. THE INSURER WILL HAVE NO LIABILITY FOR DEFENSE EXPENSES OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY.

Application Instructions

Whenever used in this Application, the term "Applicant" shall mean the Named Insured and all subsidiaries or other organizations applying for coverage, unless otherwise stated.

I. Name and Address

Name of Applicant: _____
(Include Named Insured and all additional insureds. Attach separate sheet if necessary)

Address of Applicant: _____

City: _____ State: _____ Zip Code: _____

II. Fiduciary Liability Information

Please list the names and types of Applicant's employee benefit plan(s). Attach addition pages if needed.

Plan Name(s) (Other than health & welfare plans)	Plan Assets (Current year)	Type of Plan*	Funding (DB only) Under Funded 75% or less	Number of Plan Participants	Plan Status**
	$		☐ Yes ☐ No		
	$		☐ Yes ☐ No		
	$		☐ Yes ☐ No		

**** Defined Contribution (DC), Defined Benefit (DB), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat (EBP)***
***** Active (A), Frozen (F), Sold (S), Terminated (T)-Include date of termination***

1. Does the Applicant request coverage for an Employee Stock Ownership Plan? ☐ Yes ☐ No ☐ N/A
   If "Yes", please complete the ESOP Application and provide the most recent stock valuation report.
2. Are plans and guidelines reviewed and updated annually for compliance with plan agreements, ERISA, written investment guidelines, and Health Insurance Portability and Accountability Act (HIPAA)? ☐ Yes ☐ No
   If "No", please describe:
3. In the past 3 years or the next 12 months has/will any plan:
   a. Been amended in a way that will result in the reduction of benefits? ☐ Yes ☐ No

b. Contemplated or concluded any restructuring, spin-off, transfer, consolidation, merger, termination, or other similar transaction? ☐ Yes ☐ No
If "Yes", please describe:

4. Does the Applicant handle any investment decisions in-house? ☐ Yes ☐ No
If "Yes", please describe:

5. Has any employee benefit plan:
   a. Invested in securities of the Applicant? ☐ Yes ☐ No
   b. Invested in more than 10% of any entity other than the Applicant or a pooled investment vehicle such as a mutual fund? ☐ Yes ☐ No
   c. Loaned or pledged any employee benefit plan assets to any party in interest (including the Applicant)? ☐ Yes ☐ No

If "Yes", to any of the above in Question 4., please attach a full description with details.

XI. Material Change

If any of the Applicants discover or become aware of any significant change in the condition of the Applicant between the date of this Application and the policy inception date, which would render the Application inaccurate or incomplete including but not limited to a new Claim or other matter to be reported, notice of such change will be reported in writing to us immediately and any outstanding quotation may be modified or withdrawn.

XII. Declarations, Notices, and Signature

The submission of this Application does not obligate the Insurer to issue, or the Applicant to purchase, a policy. The Applicant will be advised if the Application for coverage is accepted. The Applicant hereby authorizes the Insurer to make any inquiry in connection with this Application.

The undersigned, acting on behalf of all Applicants, declare that to the best of their knowledge and belief, after reasonable inquiry, the statements set forth in this Application and in any attachments or other documents submitted with the Application are true and complete and were made to obtain requested information from each and every Applicant proposed for this insurance to facilitate the proper and accurate completion of this Application.

The undersigned agree that the information provided in this Application and any material submitted herewith are the representations of all the Applicants and the basis for issuance of the insurance policy should a policy providing the requested coverage be issued, and that the Insurer will have relied on all such materials in issuing any such policy. Any material submitted with the Application shall be maintained on file (either electronically or paper) with us.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Insurer under any policy, of a Claim or potential Claim.

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

ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND AND WEST VIRGINIA: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or 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.

CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

FLORIDA AND OKLAHOMA: 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 in FL).

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY, 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.

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 (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

NEW HAMPSHIRE AND NEW JERSEY: Any person who includes any false or misleading information to the best of her/his knowledge on an application for an insurance policy is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

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 by 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.

VERMONT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NEW YORK: 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 civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF APPLICANT'S AUTHORIZED REPRESENTATIVE

Date _____ Signature** _____ Title _____

**This Application must be signed by the chief executive officer, president, or chief financial officer of the Applicant's parent organization acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Produced By: Producer:_____ Agency:_____

Taxpayer ID:_____ License Number:_____ Email:_____

Address (Street, City, State, Zip):_____