



## **Travelers Casualty and Surety Company of America**

**Claims-Made:** The information requested in this Application is for a Claims-Made policy. If issued, the policy will apply only to claims first made during the policy period, or any applicable extended reporting period.

**Defense Within Limits:** The limits of liability will be reduced, and may be completely exhausted, by amounts paid as defense expenses, and any retention will be applied against defense expenses. The Insurer will not be liable for the amount of any judgment, settlement, or defense expenses incurred after exhaustion of the limit of liability.

Answer each question on behalf of all entities seeking insurance coverage, unless specifically requested otherwise. An Additional Information section is provided at the end of this document for any information that exceeds the space provided.

GEI	NERAL INFORMAT	TION					
Prop	oosed Named Insured	:					
Phy	sical Address:						
City	:			State:	Zip:		
Wek	Web Address:		Telephone Number	Telephone Number (for billing inquiries):		Proposed Effective Date:	
info	rmation:		onal community association	on manager for mana	agement services co	emplete the following	
Nan	ne of Management Co	ompany:					
Add	ress:						
City	:			State:	Zip:		
<u> </u>	Check if this is the ma	iling address of the I	Named Insured.				
	GANIZATION INFO	_					
1.	Type of association:	☐ Condominiur ☐ Timeshare/Ir	<del></del>	<del></del>	owner/Property Ow ercial/Industrial/Pro		
2.	Are you a master association that oversees a group of separate sub-associations?  If Yes, for commons area only?  Yes						
3.	In the past 24 months, or in the next 12 months are you, or any builder/developer or sponsor associated with you, contemplating, or in the process of filing for bankruptcy, reorganization, or termination of corporate status, pursuant to applicable federal or state law?						
EM	PLOYEE INFORMA	ATION					
4.	Complete the follow volunteers:	ving chart providing	the number of full-time ar	nd part-time employe	ees*, officers, direct	ors, trustees, and	
	As of Date of Application			Previous 12 Months			
	Full-Time Employees	Part-Time Employees	Total Officers, Directors, Trustees (do not include volunteers)	Volunteers	Full-Time Employees	Part-Time Employees	

<sup>\*</sup>Full and part-time including leased, seasonal, and temporary employees of the Named Insured. NOTE: The employee count does not include employees of the Property Management Company.



COMM	UNITY	INFORM	ATION
	•	•	

5.	How many units or lots will the community association have upon completion?				
6.	Does one person or entity own more than 50% of the community association units?				
7.	Are there any commercial units?	☐ Yes	☐ No		
	If Yes, are any of the units bars or restaurants?	☐ Yes	☐ No		
8.	Does the builder/developer maintain any representation on your board of directors?				
9.	The average value of a unit or lot is:  ☐ Less than \$1,000,000 ☐ \$1,000,000 to \$1,999,999 ☐ \$2,000,000 or greater				
10.	Your amenities (check all that apply):  None Airport Facilities Golf Course  Marina Skiing Horse Facilities Other:				
	a. If any of the above are selected, is membership mandatory for all community association residents?	☐ Yes	☐ No		
	b. Are any of the amenities listed above open to the public?	☐ Yes	☐ No		
11.	Does the community association rent or permit the rental of any unit for a period of less than 30 days?				
FIN	ANCIAL INFORMATION				
12.	Have you had a negative fund balance within the past 3 years?	☐ Yes	☐ No		
13.	Are any renovation or improvement projects in progress or are any such projects being contemplated in the next 12 months?	☐ Yes	□No		
	If Yes:  a. Is the total value of these projects greater than \$100,000?	□Yes	□No		
	b. Is the project fully funded or have the proper amount of reserves been set aside?	 ☐ Yes	□ No		
14.	Indicate the percentage of units in arrears over 90 days:  Less than 10%  Provide your most recent fiscal year-end financial statement if you meet any of the following criteria:  a. You have requested a limit greater than or equal to \$3,000,000 for Liability Coverage.  b. You are going through a bankruptcy proceeding.  c. You have an inadequate or negative fund balance.  **EQUESTED INSURANCE INFORMATION**				
15.	Requested Limit: \$ 16. Requested Retention: \$				
17.	Expiring Limit: \$ 18. Expiring Retention: \$				
19.	Expiring Premium: \$ 20. Expiring Insurance Carrier:				
21.	As of the date you first purchased directors and officers and employment practices liability coverage, are you or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim being made against them under the coverage for which you are applying?				
D.C.	Additional Information section at the end of this Application.				
PRI	OR INSURANCE AND CLAIM HISTORY				
22.	With respect to the coverage requested in this Application, provide details or attach a loss run for all previous claims, losses, litigation, or proceedings, whether insured or not, occurring in the past five years that would fall within the scope of any directors and officers or employment practices insurance products.				
23.	With respect to the coverage requested, has there ever been any legal action taken by or on behalf of you against any member of yours (excluding liens or collection claims) or against any third party including any builder/developer?	☐ Yes	□ No		

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24.		With respect to the coverage requested, are there any pending claims, counter-claims, or litigation against any person or entity proposed for this insurance?			
	If Y	es, provide the following for each claim:			
	a.	Date of such claim:			
	b.	Nature of the claim:			
	c.	Amount paid for defense: \$			
	d.	Amount sought or paid for damages: \$			
	e.	Was the claim covered by insurance?	☐ Yes	☐ No	
	f.	Were corrective procedures implemented?	☐ Yes	☐ No	
	g.	Current status:			
	То	enter more information, provide details in the Additional Information section at the end of this Application.			

### **NOTICE REGARDING COMPENSATION**

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, Agency Compensation, One Tower Square, Hartford, CT 06183.

#### FRAUD STATEMENTS – ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

**ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, 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.

**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 the 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 to defraud or attempt 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 to defraud or attempt to defraud the policyholder or claimant regarding a settlement or award payable from insurance proceeds will be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**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.

**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.)

**LOUISIANA, MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company to defraud the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**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.

**PUERTO RICO:** Any person who knowingly and intending to defraud 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, will incur a felony and, upon conviction, will be sanctioned for each violation with the penalty of a fine of not less than \$5,000 and not over \$10,000, or a fixed term of imprisonment for three years, or both penalties. Should aggravating circumstances be present, the penalty established may be increased to a maximum of five years; if extenuating circumstances are present, it may be reduced to a minimum of two years.

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## **SIGNATURES**

the statements provided in response to this App Travelers as the basis for providing insurance. The	presents that to the best of their knowledge and be plication are true and complete, and, except in North ne Applicant will notify Travelers of any material chartion, including any requested or submitted information.	th Carolina, may be relied upon by anges to the information provided.	
*If electronically submitting this document, electronically sign this form by checking the Electronic Signature and Acceptance box above. By doing so, the Applicant agrees that use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes acceptance and agreement as if signed in writing and has the same force and effect as a signature affixed by hand.			
Authorized Representative Signature:	Authorized Representative Name and Title:	Date (month/dd/yyyy):	
Producer Name (required in FL & IA):	State Producer License No (required in FL):	Date (month/dd/yyyy):	
Agency:	Agency Phone Number:		
ADDITIONAL INFORMATION			

# Administered By:

Kevin Davis Insurance Services, a division of Worldwide Insurance Services of DE., Inc. an Amwins company 800 W  $6^{th}$  St. Ste 1700, Los Angeles, CA 90017

This area may be used to provide additional information to any question. Reference the question number.

Phone: (213) 833-6191

CA Insurance License Number 0M80105