



Euclid Vanguard  
Fiduciary Liability  
Insurance Application

**SOLIDARITY PROTECTION GROUP**

a voluntary membership organization operating pursuant to the Liability Risk Retention Act of 1986 and whose principal office is:  
4323 Warren Street, NW, Washington, DC 20016-2437

**FIDUCIARY LIABILITY INSURANCE FOR EMPLOYEE BENEFIT PLANS**

The policy for which application is made is written on a claims-made basis. The coverage afforded by this policy is limited to liability for only those claims first made during the policy period specified on the Policy Certificate resulting from wrongful acts and which are subsequently reported to the Insurer as soon as practicable. This is a policy with claims expenses included in the limits of liability. The limits of liability shall be reduced and may be exhausted by claims expenses, and to the extent that the limits of liability are thereby exceeded, the Insurer shall not be liable for claims expenses or any other loss. Please read everything carefully.

**I. GENERAL INFORMATION**

GENERAL INFORMATION	
Name of Plan Sponsor or Plan (name as it should appear on the policy, if written):	
Address:	
EIN Number for all plans:	
Date Established:	
Website Address:	
Insurance Representative:	
Address:	
Phone Number:	
E-mail address:	
Plan Administrator (if different from the Named Insured):	

**II. NAME AND TYPE OF PLAN OR TRUST**

Complete the chart for all trusts or plans for which coverage is requested:

Full Plan or Trust Name	*Type	Current Asset Value	Last FYE Annual Contributions	Current # of Participants	** Status

\* Types: Defined Benefit (DB); Defined Contribution (DC); Welfare Benefit Plan (W); Other (O) – Attach Explanation

\*\* Status: Active (A); Frozen (F); Terminated (T) (If any trust or plan has been terminated, indicate date of transaction)

### III. INSURANCE INFORMATION

Prior Insurance Carrier(s):	Policy Period	Limit of Liability	Retention	Premium

Fiduciary Liability	
If no prior coverage, explain:	
Requested Effective Date:	
Requested Limit of Liability:	
Requested Retention:	
Number of current trustees of the Plan:	
Number of Plan employees (if applicable)	
Prior Policy Number:	

Service Provider	Name of Professional Service Provider	Years of Service
Professional Administrator:		
Legal Counsel:		
Actuary:		
Certified Public Accountant:		
Investment Manager(s):		
Other:		
Other:		

Have any Service Provider changes been made in the last year? If "Yes" please provide written details with explanation.	Yes _____	No _____
---	-----------	----------

### IV. UNDERWRITING QUESTIONS

#### Questions Common to all Types of Plans:

- PLAN AMENDMENTS:** Have there been any amendments to the Plan in the past 36 months, or are any such amendments anticipated in the next 12 months that have/will increase or decrease the value of benefits? **If Yes, please attach a copy of all plan amendments in past 36 months or drafts of intended plan amendments.**

Yes \_\_\_\_\_ No \_\_\_\_\_
- When was the last time the plan or its advisors received any communication or been the subject of an investigation or audit by any regulatory agency, including the Department of Labor or the Internal Revenue Service?
- Has the plan entered into the DOL or IRS voluntary correction program in the last five years? If so, please explain the circumstances.
- Who administers the daily operations of the Plan(s)?
- Is the person administrating the daily operations of the Plan(s) employed by the Plan or a third-party administrator? \_\_\_\_\_
- Does the Plan have current coverage under a fidelity bond that complies with ERISA? Yes \_\_\_\_\_ No \_\_\_\_\_

**Defined Benefit Plan Questions:** If not applicable please check: N/A \_\_\_\_\_

7. Have there been any amendments to the Plan in the past 36 months that resulted in a reduction in benefits, or are any such amendments anticipated in the next 12 months? Yes \_\_\_\_\_ No \_\_\_\_\_
8. Has the actuary certified that the Plan is adequately funded under applicable law? Yes \_\_\_\_\_ No \_\_\_\_\_
9. What is the current plan PPA funding percentage? \_\_\_\_\_
10. Does the board of trustees have a written procedure to collect overdue and delinquent contributions? Yes \_\_\_\_\_ No \_\_\_\_\_
11. Are there any overdue or delinquent contributions? Yes \_\_\_\_\_ No \_\_\_\_\_
12. Does the plan outsource plan administration to a third-party administrator? Yes \_\_\_\_\_ No \_\_\_\_\_
13. Does the plan use a 3(21) or 3(38) investment advisor for all or part of the plan's investments? Please describe any such arrangement: \_\_\_\_\_  
\_\_\_\_\_  
Yes \_\_\_\_\_ No \_\_\_\_\_
14. Please describe how the plan is locating any missing participants, and any updates to its procedures in the last three years? \_\_\_\_\_  
\_\_\_\_\_  
Yes \_\_\_\_\_ No \_\_\_\_\_
15. Has the Plan updated its policy for monitoring the reasonableness of all plan expenses in the last five years? Please attach a copy of the plan's expense policy. Yes \_\_\_\_\_ No \_\_\_\_\_
16. How does the plan identify any miscalculation of benefits? \_\_\_\_\_  
\_\_\_\_\_  
Yes \_\_\_\_\_ No \_\_\_\_\_
17. Has the plan identified any overpayment of benefits to any plan participants? Yes \_\_\_\_\_ No \_\_\_\_\_

**For any Multiemployer Defined Benefit Pension Plan, please answer the following additional questions:** If not applicable please check: N/A \_\_\_\_\_

18. What is the current Zone Status of the Plan(s)?  
Please check: Green: \_\_\_\_\_ Yellow: \_\_\_\_\_ Red: \_\_\_\_\_ Critical and Declining? \_\_\_\_\_
19. For any plan not in the Green Zone, what is the expected insolvency date calculated by a plan actuary? \_\_\_\_\_
20. Are there any overdue, outstanding or delinquent employer contributions? Yes \_\_\_\_\_ No \_\_\_\_\_
21. Is a Funding Improvement/Rehabilitation Plan currently in place or contemplated in the next 12 months by the Plan(s)? Yes \_\_\_\_\_ No \_\_\_\_\_
22. Is the Plan is intending to seek relief under Multiemployer Pension Reform Act "MPRA." If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
Yes \_\_\_\_\_ No \_\_\_\_\_

**Joint Apprenticeship Training Fund/Plan/Committee Questions:**  
If not applicable please check: N/A \_\_\_\_\_

23. Does the Joint Apprenticeship Training Fund/Plan/Committee have an expense policy that complies with the Department of Labor modesty expense policy (DOL Field Assistance Bulletin 2012-01 on April 2, 2012 entitled *Citing Apprenticeship and Training Plans for Using Plan Assets for Graduation Ceremonies and Program Marketing*). Yes \_\_\_\_\_ No \_\_\_\_\_
24. Has the written expense policy been reviewed by an attorney with fiduciary liability experience? Yes \_\_\_\_\_ No \_\_\_\_\_
24. When was the Fund/Plan/Committee most recently audited by the DOL? Date: \_\_\_\_\_
25. Does the expense policy include any of the following: 1) Does the policy allow employees to use plan-owned automobile for personal or after work hours purposes? 2) Does the policy allow payment for any graduation expenses out of Plan assets? and 3) Does the policy allow payment for alcohol at any Plan event? If so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

**Defined Contribution Plan Questions: If not applicable please check: N/A \_\_\_\_\_**

26. Has there been any failure to timely transmit to the plan any participant contributions? Yes \_\_\_\_\_ No \_\_\_\_\_
27. What is the time period in which participant contributions are deposited to the plan?  
\_\_\_\_\_  
\_\_\_\_\_
28. Does the plan provide that all investment options are participant directed? Yes \_\_\_\_\_ No \_\_\_\_\_
29. Are there any loans by the plan listed in default classified during the year as uncollectible? Yes \_\_\_\_\_ No \_\_\_\_\_
30. Does the plan offer low-cost index fund options? Yes \_\_\_\_\_ No \_\_\_\_\_
31. Please give detailed explanations of the due diligence performed on the fees for the defined contribution plan, including a copy of all such performance reviews to review the performance of the investment choices in the plan:  
\_\_\_\_\_  
\_\_\_\_\_
32. Please describe the process for reviewing the reasonableness of the fees charged for each investment option including the last time fees were lowered:  
\_\_\_\_\_  
\_\_\_\_\_
33. Please describe the process for reviewing the reasonableness of participant fees charged by the recordkeeper (whether a flat fee or percentage of assets), and please provide the amounts charged to plan participants:  
\_\_\_\_\_  
\_\_\_\_\_
34. Please describe the terms of any revenue sharing agreements and whether any such agreement has been reviewed by an independent fiduciary:  
\_\_\_\_\_  
\_\_\_\_\_
35. Please describe your plan committee's process for evaluating the reasonableness of service provider fees and, in particular, your record keeper(s) including the frequency of evaluations and whether you involve outside consultants:  
\_\_\_\_\_  
\_\_\_\_\_
36. Do you periodically benchmark and/or RFP your provider services and fees, and if so, please describe including when was the last RFP was done for a plan recordkeeper, and when will the next RFP be held:  
\_\_\_\_\_  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
37. How many record keepers does the Plan have and on what basis do you pay your recordkeeper(s) (per capital, flat fee, assets under management/revenue sharing)? How much do you pay for recordkeepers on a per capita basis? Is there revenue sharing, and if so, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

38. Please describe your investment committee's process for evaluating the prudence and performance of plan investment options, including the frequency of evaluations and whether you involve outside consultants. Please explain whether you evaluate investment performance net of expense:

---



---

39. Please provide a copy of the 408(b) fee disclosures made to the plans and the 404 fee disclosures made to participants.

40. Please indicate whether you have received any inquiries from the law firm of Schlichter, Bogard & Denton, The Levin Firm, or any other law firm, and if so, when. Please describe any follow up communications or actions re same.

---



---

If not applicable please check: N/A \_\_\_\_\_

**For Health and Welfare Plans: If not applicable please check: N/A \_\_\_\_\_**

41. Is the plan fully insured or self-funded? \_\_\_\_\_

42. Does the plan self-administer or use a third-party administrator to administer the plan?

43. Does the plan document contain an anti-assignment provision to prevent assignments of rights to health care providers? Yes \_\_\_\_\_ No \_\_\_\_\_

44. How does the plan handle the portion of uncovered bills from health care providers charged to participants?

45. What actions has the plan taken to comply with the Mental Health Parity Act to ensure that all mental health benefits are in parity with other benefits under the plan?

---

46. What actions has the plan taken to ensure that the plan document conforms to the requirements of the Affordable Care Act?

- Have participants been notified of their right to designate any participating primary care provider, pediatrician, or obstetrician/gynecologist? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have participants received sufficient notice of the plan's coverages of emergency services? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have participants received sufficient notice of the plan's coverage for preventative services? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have participants received sufficient notice of the plan's internal claim and appeals and external review processes? Yes \_\_\_\_\_ No \_\_\_\_\_

**Loss History. If any question is answered 'Yes' a written attachment is required. Section not applicable for renewals only. If so, state "Renewal": \_\_\_\_\_**

47. Has any trustee or employee of the Plan been:
- a. accused, found guilty or held liable for a breach of trust or fiduciary duty Yes \_\_\_\_\_ No \_\_\_\_\_
  - b. accused or convicted of criminal conduct? Yes \_\_\_\_\_ No \_\_\_\_\_
  - c. refused coverage under a fidelity bond? Yes \_\_\_\_\_ No \_\_\_\_\_
48. Are there any current claims outstanding against the Plan or any fiduciaries? Yes \_\_\_\_\_ No \_\_\_\_\_
49. Have any claims been made against the Plan or any fiduciaries in the past 6 years? Yes \_\_\_\_\_ No \_\_\_\_\_

50. Has the Plan received any communication from or been the subject of any investigation or audit by the IRS, DOL or any other regulatory agency? Yes \_\_\_\_\_ No \_\_\_\_\_
51. Has the Plan experienced a reportable transaction to the PBGC? Yes \_\_\_\_\_ No \_\_\_\_\_
52. Has any application for fiduciary liability coverage or fidelity bond insurance been declined, canceled or non-renewed? Yes \_\_\_\_\_ No \_\_\_\_\_
53. Does the Plan, the board of trustees, current employees or any other proposed fiduciary have any knowledge of or information pertaining to any facts, events or circumstances which may result in a claim being made against them under the proposed policy? Yes \_\_\_\_\_ No \_\_\_\_\_

It is agreed that, if knowledge of any facts, events or circumstances exist, whether or not disclosed, any claim based upon or arising from them, and that any claim based upon or arising from any pending or prior proceeding, is excluded from the proposed coverage.

## V. REQUIRED ATTACHMENTS

The following information must be attached for each Plan to be covered under the proposed policy:

- List of current trustees along with years of experience
- Most recent Audited Financial Statements for the Plan (s) completed by the CPA
- Most recent Form 5500s or 990s, including all schedules
- Most recent Actuarial Report, Actuarial Zone Certification and applicable Funding Improvement & Rehabilitation Plan as required by the Pension Protection Act of 2006 (only for defined benefit pension plans)
- Copy of the investment policy and/or guidelines
- For Defined Benefit Plans - attach a copy of the plan's expense policy
- For Defined Contribution Plans - provide a copy of the 408(b) fee disclosures made to the plans and the 404 fee disclosures made to participants. Also, include copies of performance reviews analyzing performance of the investment choices in the plan.
- If available/applicable, attach a copy of the governmental immunity statute for the state the risk is domiciled in
- Required attachments to underwriting questions, if any

Insurance Representative, please submit this application and all required attachments to:

**EBERTS & HARRISON**  
*Union Insurance by Union Agents*

1604 Ridgeside Drive, Suite 203, Mount Airy, Maryland 21771  
Phone (301) 596-3940 - Fax: (303)596-5543  
Christian@ebertsandharrison.com

## VI. SIGNATURE

The undersigned represents, that to the best of his/her knowledge and belief the statements set forth herein are true, and he/she has not withheld any information which is reasonably likely to influence the judgment of Hudson Insurance Company in considering this application for fiduciary liability insurance. The undersigned further represents that if the information supplied on this application changes between the date of this application and the effective date of the insurance or the time when the policy is bound (whichever is later), the undersigned will immediately notify Hudson Insurance Company in writing of such changes and Hudson Insurance Company may withdraw or modify any outstanding quotations based upon such changes. The signing of this application does not bind Hudson Insurance Company to complete the insurance, but it is agreed that this application and any attachments form the basis of the contract should a policy be issued and shall be deemed attached to and form part of a policy. Hudson Insurance Company is hereby authorized to make any investigation and inquiry in connection with this application it deems necessary. **Please note electronically reproduced signatures will be treated as original.**

Authorized Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**VII. FRAUD WARNINGS**

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

**NOTICE TO OKLAHOMA APPLICANTS:** 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 injure, deceive, defraud any insurer or other person files an application or a claim containing any false, incomplete or misleading information or conceals information concerning any material fact may be guilty of insurance fraud, which is a crime and may subject such 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.

**NOTICE TO APPLICANTS IN AR, FL, KY, MN, NJ, AND PA:** 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.

**NOTICE TO ALL OTHER APPLICANTS:** Any person who knowingly and with intent to injure, deceive, defraud any insurer or other person files an application or a claim containing any false, incomplete or misleading information or conceals information concerning any material fact commits insurance fraud, which is a crime and subjects such person to criminal and civil penalties.

**VIII. ADDITIONAL INFORMATION OR EXPLANATION**

**Please provide additional information or explanation, as needed.**

---

---

---

---

---

---

---

---

---

---

**IX. CLAIMS INFORMATION**

<b>General Information</b>	
Name of Claimant:	
Date of Alleged Wrongful Act:	
Date claim was made:	
Date reported to Fiduciary Liability Insurer:	
Name of Fiduciary Liability Insurer:	
Allegation:	
<b>Describe the claim, including the alleged wrongful act, the event that led to the claim, and the current status of the claim:</b>	
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	
<b>Claim Information</b>	
Total Loss:	\$
Claimant Demand:	\$
Legal Fees Charged to Date:	\$
<b>What loss prevention measures, if applicable, have been taken to prevent a similar claim from recurring?</b>	
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	

Please attach additional information as needed.