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Renewal Application

Fiduciary Liability Insurance

Submitting Broker, please complete the following to assist us in processing this submission:

Name of Brokerage: ____________________

Name of Broker Contact: ____________________

Brokerage Address: ____________________ City: __________ Postal Code: __________

For renewal purposes only: Policy Number: ____________________ ISN (Client's Number): ____________________

Note: **1. All questions must be completed in their entirety.**

2. Capitalized terms used herein are defined in the policy wording.

ADDITIONAL INFORMATION REQUIRED

Please submit the following information to complete your submission:

(a) latest actuarial report and financial statements for each BENEFIT PLAN;

(b) list of INSURED PERSONS.

SPONSOR ORGANIZATION

1. (a) Name: ____________________

(b) Address: ____________________

____

(c) Website: ____________________

(d) Incorporated under the laws of: ____________________ Incorporation Date: __________

(e) Nature of business: ____________________

BENEFIT PLAN(S)

2. (a) Name: ____________________

(b) Number of participants: Active: __________ Retired: __________

(c) Type of Plan: ☐ Defined Benefit ☐ Defined Contribution ☐ Welfare/Trust Fund
☐ ESOP ☐ RRSP ☐ Other

(d) Year plan established: ____________________

(e) Total plan assets: ____________________

(f) Plan administrator: ____________________

(g) Investment manager: ____________________

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(h) Is the plan adequately funded as attested to by any actuary (applies to Defined Benefit plans only)? YES ☐ NO ☐

If yes, please provide the actuarial report. If no, please provide details:

(i) Does the SPONSOR ORGANIZATION or any SUBSIDIARY plan on terminating, suspending, merging or dissolving any plan within the next 12 months? YES ☐ NO ☐

If yes, please provide details:

(j) Is this the only plan for which Fiduciary Liability coverage is being sought? YES ☐ NO ☐

If no, please provide a schedule to this Application with answers to questions 2 (a) through (i) for each plan.

WITHOUT LIMITATION TO ANY OTHER REMEDY AVAILABLE TO THE INSURERS, THE PROPOSED INSURANCE WILL NOT AFFORD COVERAGE TO ANY CLAIMS OF WHICH ANY INSURED HAS KNOWLEDGE NOR ANY CLAIMS RESULTING FROM ANY FACTS OR CIRCUMSTANCES OF WHICH ANY INSURED HAS KNOWLEDGE.

APPLICANT'S CONSENT TO THE TRANSMISSION OF THE INFORMATION CONTAINED IN THE APPLICATION FORM

I hereby acknowledge that the information collected in the Application form is acquired by my insurance broker to be transmitted to Victor Insurance Managers Inc. for the sole purpose of obtaining an insurance policy, and will be kept confidential.

Moreover, I authorize Victor Insurance Managers Inc., its insurers or service providers to:

- conduct verification, using outside sources, of the information contained in the Application form, in attached documentation and in subsequently provided documentation;
- in the event of a claim, transmit the submitted and verified information to loss adjusters, lawyers or other similar offices for the purposes of investigating, defending, negotiating or settling any claims, as required.

For more information on Victor's privacy policy, please contact privacypolicyinquiries@victorinsurance.com.

DECLARATIONS AND SIGNATURE

The undersigned declares that:

(a) he/she is duly authorized by the SPONSOR ORGANIZATION to complete this Application and that the statements set forth herein are true and complete;

(b) reasonable efforts have been made to obtain sufficient information from each person proposed for coverage to facilitate the proper and accurate completion of this Application form;

(c) the financial information submitted with this Application are representative of the current financial position of the BENEFIT PLAN(S) (if not, please attach details).

The undersigned agrees that:

(a) if the information supplied in this Application changes between the date of this Application and the effective date of the policy, he/she will provide written notice of such changes immediately to the INSURANCE MANAGER and, without limitation to any other remedy, the INSURANCE MANAGER may withdraw or modify any outstanding quotations, and any authorization or agreement to bind coverage;

(b) should a policy be issued, this Application and its attachments shall form part of the policy.

Signature of Authorized INSURED	Capacity
Date (dd/mm/yyyy)	Company

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