

Chubb Group Insurance Companies

15 Mountain View Road, Warren, NJ 07059

**APPLICATION
PENSION AND WELFARE FUND
FIDUCIARY DISHONESTY POLICY**

FEDERAL INSURANCE COMPANY

Name of Plan: _____

Name of Sponsor Organization: _____

Address of Sponsor Organization: _____

Coverage Requested:

Fiduciary Dishonesty Coverage \$ _____

Fiduciary Dishonesty Coverage is sold in limits from \$10,000 to \$5,000,000.

Policy Period: From _____ to until cancelled.

Plan Information:

Is this an insured Plan? (i.e., one from which benefits are paid from a insurance contract) _____

Is this a funded Plan? (i.e., one whose assets are segregated from those of the Employer) _____

If a funded Plan, is a bank or other institution acting as trustee? _____

(Name of bank or institution)

If a bank or other institution does not act as trustee, explain who has custody and control of the Plan's assets. _____

Are the Plan's books and accounts audited by a C.P.A.? _____

(Name of C.P.A.)

How often? _____ Are the audits complete? _____

(If not audited by a C.P.A. or if not complete, please attach explanation)

If the Plan has bank accounts in its own name, are bank statements reconciled monthly? _____

Do the employees who reconcile also either (a) sign checks? _____, (b) handle deposits? _____, or (c) have access to check signing machines or signature plates? _____

(It is inadvisable for the reconciliation to be done by an employee who also signs checks, handles deposits or who has access to check signing machines or signature plates because under such circumstances losses may be concealed. If the answer to this question is yes, will you correct this weakness? _____)

Securities Information:

Value of *negotiable* securities owned or held by the Plan: _____

(If none, so state)

Where are the negotiable securities kept: _____

If safe deposit boxes are used, has the bank been instructed to require that two individuals be present before any entry to any box is permitted? _____

If not, how many individuals have single access to the boxes and will you identify them by name and position? _____

Plan Census:

All natural persons as described in Title 1 of the Employee Retirement Income Security Act of 1974 who "handle" funds or other property of the Plan should be included.

Number

Administrator and officials "handling" tools _____

Employee "handling" funds _____

All other persons "handling" funds _____

Indicate those of the above not officers or employees of the Employer _____
(If more than one plan is to be covered under the same policy please avoid duplicate declaration of personnel.)

Loss Experience:

Record below any losses sustained during the past five years showing date and amount of each.

Date of Loss	Amount of Loss	Date of Loss	Amount of Loss
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The person completing this application on behalf of all persons for who coverage is requested affirms that all the information contained herein is complete and correct to the knowledge of all persons who may be covered.

Date: _____ 20 _____ Signed _____
Name Title
(Proprietor, Partner or Officer)

Please complete one of these forms for **each** Employee Benefit Plan