

Item IV.	CODA Access Fund \$ _____ Public Relations Fund: \$ _____ Enforcement Fund: \$ _____ The amount stated for the CODA Access Fund is in addition to the Limit of Liability and any applicable reinstatements set forth in Item III above and the maximum amount the INSURER shall pay for such CODA Access Fund. The Public Relations Fund and Enforcement Fund are sublimits that are part of, and not in addition to, the Limit of Liability and any applicable reinstatements set forth in Item III above.
Item V.	POLICY Premium: \$ _____ DISCOVERY PERIOD Premium: _____ % of POLICY Premium
Item VI.	Notice to COMPANY: Any notice to the COMPANY or, except in accordance with Clause 16 (Authority) of this POLICY, to the INSUREDS, shall be given or made to the individual listed above, if any, or otherwise to the individual designated in the APPLICATION, if any, or otherwise to the signer of the APPLICATION, and shall be given or made in accordance with Clause 15 (Notice) of this POLICY.
Item VII.	Notice to INSURER: Any notice to be given or payment to be made to the INSURER under this POLICY shall be given or made in accordance with Clause 15 (Notice) of this POLICY to: A. Notice of CLAIM or WRONGFUL ACT: Attention: Specialty Products Claims Chubb Insurance Company of Canada 199 Bay Street, Suite 2500, PO Box 139, Commerce Court Postal Station Toronto, Ontario, M5L 1E2 Canada B. All payments or other notices: Chief Underwriting Officer Chubb Insurance Company of Canada 199 Bay Street, Suite 2500, PO Box 139, Commerce Court Postal Station Toronto, Ontario, M5L 1E2 Canada INFORMATION SUBMITTED TO THE INSURER WHICH IS NOT PROPERLY ADDRESSED TO THE CLAIMS DEPARTMENT SHALL NOT CONSTITUTE A VALID NOTICE OF CLAIM.

Item VIII.	Schedule of Underlying Directors' and Officers' insurance:				
	<u>Carrier</u>	<u>Policy No.</u>	<u>Policy Period</u>	<u>Limits</u>	<u>Attachment</u>
Primary Policy:	_____				
Excess Policies:	_____				

IN WITNESS WHEREOF, the INSURER has caused this POLICY to be countersigned by a duly authorized representative of the INSURER.

DATE: _____

Authorized Representative