RPG DIRECTORS' & OFFICERS' LIABILITY

including Employment Practices Liability for Not-for-Profit Organizations (Claims-made Coverage)
Insurance Program and Enrollment Form
This brochure is valid for effective dates from 3/1/17 through 2/28/18

PROGRAM DESCRIPTION

This program provides important protection to eligible organizations for claims arising out of allegations of errors, omissions or wrongful acts committed by its directors, officers, employees or volunteers. This coverage will respond to allegations of discrimination, wrongful dismissal, acts beyond granted authority, failure to deliver services and wrongful employment practices. In addition, coverage provides medical expense payments for a bodily injury loss caused by an accident that takes place during activities that are customary to your business in the covered territory for the directors and officers of the named insured.

Defense costs are paid in addition to the limit of liability and coverage is provided on a claims-made basis, applying only to claims first made during the coverage period.

Coverage is provided by a carrier rated A+ (Superior) by A.M. Best Company.

INELIGIBLE OPERATIONS

Organizations that do not meet the eligibility criteria listed in this brochure are not eligible for this program as well as:

- Booster clubs (those supporting/funding interscholastic/intercollegiate athletic programs)
- Governmental entities or organizations

(**Note:** This is not a complete list of ineligibles)

FOUR EASY WAYS TO ENROLL FOR COVERAGE

WEB Receive coverage immediately by purchasing online at **www.ascensionins.com/programs**

OR

Submit this enrollment form, with payment, to us.

E-MAIL programs@ascensionins.com

FAX 1-913-327-0201

MAIL

Regular:
Ascension Benefits & Insurance Solutions
P.O. Box 25936
Overland Park, KS 66225

Overnight:
Ascension Benefits & Insurance Solutions
9225 Indian Creek Parkway, Suite 700
Overland Park, KS 66210

QUESTIONS **Call 1-800-955-1991**

ELIGIBLE OPERATIONS

Organizations that meet all of the following criteria are eligible to submit an enrollment form for coverage under this program:

1. The organization has tax exempt status as a not-for-profit organization.
2. The annual gross revenue of the organization from all sources is $3,000,000 or less.
3. The organization has obtained general liability coverage through a supporting Sports, Leisure and Entertainment Risk Purchasing Group Insurance Program offered by us.

COVERAGE AND LIMITS

This program provides two limit options to choose from.

Option A	
Maximum Aggregate Limit of Liability	$ 1,000,000
Retention (each claim)	$ 1,000
Medical Payments for Directors' & Officers' (per director or officer)	$ 10,000
Premium (based on annual gross revenue)	
$ 0 - $1,000,000	$ 625.00
$1,000,001 - $2,000,000	$ 1,075.00
$2,000,001 - $3,000,000	$ 1,525.00
$3,000,001 or higher	Refer to us

Option B	
Maximum Aggregate Limit of Liability	$ 2,000,000
Retention (each claim)	$ 1,000
Medical Payments for Directors' & Officers' (per director or officer)	$ 10,000
Premium (based on annual gross revenue)	
$ 0 - $1,000,000	$ 950.00
$1,000,001 - $2,000,000	$ 1,650.00
$2,000,001 - $3,000,000	$ 2,325.00
$3,000,001 or higher	Refer to us

This brochure is for illustrative purposes only and is not a contract of insurance. You must refer to the actual policy for complete information regarding coverage terms, conditions and exclusions, as they may change from one coverage period to the next.

EXCLUSIONS

The following represent only some of the exclusions contained in this policy.

- Advertising injury
- Bodily injury
- Failure to maintain proper insurance
- Fungi
- Injunctive relief or any other relief or recovery other than monetary judgement, award or settlement
- Nuclear energy
- Personal injury
- Pollutants
- Property damage
- Wrongful death

COVERAGE INFORMATION

The following are several coverage explanations related to a claims-made policy that should be considered.

Claims-made During Policy Period
This policy covers only claims actually made or incidents reported against the insured while the policy remains in effect, or any applicable extended reporting period. All coverages under the policy ceases upon the termination date, except for the automatic extended reporting period coverage, unless the insured purchases additional extended reporting period coverage.

Extended Reporting Period
The automatic extended reporting period is sixty (60) days from the termination or expiration date of the policy. The additional extended reporting period, if purchased, may be up to three (3) years for not-for-profit policies. If this extended reporting period is not purchased and the subsequent policy does not provide full prior acts coverage or is an occurrence policy, there may be gaps in coverage.

FREQUENTLY ASKED QUESTIONS

1. **Can I apply for coverage over the phone?**

   Unfortunately, we are not able to take your information over the phone at this time. You can apply for coverage online or by completing an enrollment form and submitting it to us via e-mail, fax or mail.

2. **Does D&O liability cover allegations against the board for abuse, molestation, harassment or sexual conduct?**

   This type of allegation would be covered under the abuse, molestation, harassment or sexual conduct defense cost reimbursement coverage which is available for purchase as an optional coverage with a commercial general liability policy through a supporting Sports, Leisure and Entertainment Risk Purchasing Group offered by us.

3. **Does D&O liability provide coverage if a member of the board embezzles money from our funds?**

   Embezzlement is not covered under this D&O liability policy.

4. **Does D&O liability provide coverage if a participant is injured during a covered activity?**

   No, this would be covered under the medical payments for participants coverage, if eligible, that is provided with a commercial general liability policy through a supporting Sports, Leisure and Entertainment Risk Purchasing Group Insurance Program offered by us. This program only offers medical payments coverage to the directors and officers of the insured, if injured during their scope of duties on behalf of the insured.

5. **Can any board member complete and sign the D&O liability enrollment form?**

   The carrier requires that the enrollment form for D&O liability coverage be completed and signed by either the President, Executive Director or the Treasurer of the board.

6. **Will I receive a policy after I submit the enrollment form?**

   If you are a new account, you will receive a copy of the policy. Renewal accounts will only receive a certificate of insurance evidencing coverage.

Enrollment Form - RPG Directors' & Officers' Liability

including Employment Practices Liability Insurance for Not-for-Profit Organizations (Claims-made Coverage)

Valid for effective dates from 3/1/17 through 2/28/18

Completion of this enrollment form confirms your desire to obtain insurance through the Sports, Leisure and Entertainment Risk Purchasing Group. An RPG provides group purchasing power for similar risks resulting in potential advantageous coverage terms, competitive rates, risk management bulletins, and rewards for favorable group loss experience. An RPG membership fee may be charged. The submission of this enrollment form and/or the acceptance of payment does not guarantee coverage. Certain operations are not eligible for coverage by this program. We reserve the right to decline any request for coverage.

TO AVOID PROCESSING DELAYS, PLEASE:
1. **Complete all sections (print legibly)**
2. **Sign and date where required**
3. **Remit completed enrollment form (pages 3 - 6) with payment**

GENERAL INFORMATION

❍ I am a new account ❍ I am renewing my coverage

Full legal name of business: _____

Note: This is the name that will appear on your Certificate of Insurance. If your company is a Sole Proprietorship, then this will be your personal name or DBA.

Applicant is a: ❍ Sole Proprietorship ❍ Limited Liability Co. ❍ Corporation ❍ Partnership
❍ Other (describe):_____

Mailing address: _____

City: _____ State: _____ Zip: _____

Contact name: _____

Phone: (_____) _____ Cell: (_____) _____ Fax: (_____) _____

E-mail: _____ Website: _____

DATES

Coverage will begin the day after the completed enrollment form and premium are received and approved by us, or on a later date you specify below. (If renewing coverage, please provide the expiration date of your current policy.) ❍ Start my coverage on this date: _____ / _____ / _____

BUSINESS INFORMATION

1. Form of business: ❍ Not-for-profit organization ❍ For-profit organization
2. Do you currently have commercial general liability coverage with us? ❍ Yes ❍ No
   If yes, please check the program from which you have purchased this coverage through us.
   ❍ Teams, Leagues & Associations Program ❍ Dance Schools & Programs
   ❍ Gymnastics Clubs & Cheer Gyms Program ❍ Martial Arts Schools & Programs
   ❍ Activity & Social Clubs Program
3. Date organized/established: _____ / _____ / _____ Tax ID #: . . . . . _____
4. Number of full-time compensated employees (over 30 hours a week for 12 months): . . . . . _____
5. Number of part-time compensated employees (under 30 hours a week or less than 12 months):_____
6. Number of volunteers (not including board members): . . . . . _____
7. Total annual gross revenue for the organization (gross revenue includes all receipts from fees, sponsorships, fundraisers, membership, ticket sales): . . . . . $_____
8. Total assets for the organization (example: sports equipment, concession stand equipment): $_____
9. Total liabilities for the organization (example: loans):. . . . . $_____

Ascension Benefits & Insurance Solutions • P.O. Box 25936 • Overland Park, KS 66225 • 1-800-955-1991
E-mail = programs@ascensionins.com • Fax 1-913-327-0201 • www.ascensionins.com/programs

PAST ACTIVITIES WARRANTY

NEW ACCOUNTS ONLY – Complete this section only if this is a new enrollment form with us.
Does your organization currently have D&O liability in force with another insurance company? ❍ Yes ❍ No
If yes, please provide the following:

Carrier: _____ Limit: _____
Premium: $_____ Exp. date: ____ / ____ / ____

Past Activities:

No claim that would fall within the scope of the proposed insurance has been made against any person or entity proposed for this insurance (including without limitation any claim against such person or entity for any employment practice, as described in the proposed insurance, or any complaint against any such person or entity before the Equal Employment Opportunity Commission or any similar state or local authority), except as follows (include the loss payment and defense cost):

If so, explain: _____
_____
If none, check here ❍

No person or entity proposed for this insurance is cognizant of any fact, circumstance or situation (including without limitation any suspected or threatened claim against any such person or entity for any employment practice, as described in the proposed insurance, or any suspected or threatened complaint against any such person or entity before the Equal Employment Opportunity Commission or any similar state or local authority) which might afford grounds for any claim that would fall within the scope of the proposed insurance, except as follows:

_____
If none, check here ❍

PROGRAM PREMIUM

Premium (based on annual gross revenue)	**Option A $1,000,000 Limit**	**Option B $2,000,000 Limit**
$ 0 - $ 1,000,000	❍ $625.00	❍ $950.00
$ 1,000,001 - $ 2,000,000	❍ $1,075.00	❍ $1,650.00
$ 2,000,001 - $ 3,000,000	❍ $1,525.00	❍ $2,325.00
$ 3,000,001 or higher	Refer to company	Refer to company

OFFICE USE ONLY

UW Rec:_____/_____/_____ Status: N R Broker: Y N Comm:_____% OPS Rec:_____/_____/_____
D&O Exp Policy#:_____ /CP #:_____Exp Dates:_____/_____/_____ to _____/_____/_____
Delivery M F E Date:_____/_____/_____ Pay Plan :_____ Bill: AB AD CBG
D&O Policy #:_____/CP #:_____ D&O Prem:_____ Eff Date:_____/_____/_____ to _____/_____/_____
Comments:_____ Insured #:_____

DOCUMENT DELIVERY

You will receive a certificate showing evidence that coverage has been bound. This coverage document will be delivered via e-mail, unless otherwise indicated below. If you have an insurance agent, all documents will be delivered to your agent only. Additional certificate requests will be delivered to the same person. Please select only one option.

❍ E-mail to: _____ attn: _____

(selecting this option confirms your consent for coverage documents to be delivered via e-mail)

❍ Fax to: _____ attn: _____

❍ Mail to: _____ attn: _____

AGENTS ONLY

TO BE COMPLETED ONLY IF LICENSED INSURANCE AGENT IS SUBMITTING THIS FORM

Agency name: _____

Agency mailing address: _____

City: _____ State: _____ Zip: _____

Agent/contact name: _____

Agency telephone: (_____)_____ Agency fax: (_____) _____

Agent/contact e-mail address: _____Tax ID #: _____

WARRANTY STATEMENT

I understand that the insurance company, in determining whether to provide insurance coverage, will rely on the information contained in this form and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

I am aware that the insurance company expects accurate reporting for my premium calculation. I understand that my books and records may be examined or audited by the insurance company at any time during the coverage period and up to three years thereafter. Intentional misrepresentation or misreporting may jeopardize coverage.

I further acknowledge that, I have reviewed all information provided with this enrollment form and understand the exclusions which apply, as well as the activities and operations for which coverage is not provided.

Applicant signature: _____ Date: _____

(Must be signed by president, executive director, or treasurer acting as an authorized agent of the organization)

Printed name: _____ Title: _____

Named insured (from page 3): _____

GENERAL FRAUD STATEMENT

Applicable in AL, AR, DC, LA, MD, NM, RI and WV
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO 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.

Applicable in FL and OK Any person 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)*. *Applies in FL Only.

Applicable in KS Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH 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* (not to exceed five thousand dollars and the stated value of the claim for each such violation)*.*Applies in NY Only.

Applicable in ME, TN, VA and WA It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

PREMIUMS ARE 100% FULLY EARNED AND NON-REFUNDABLE ONCE COVERAGE BEGINS. COVERAGE IS CONTINGENT UPON RECEIPT OF PAYMENT. NO COVERAGE WILL BE DEEMED IN EFFECT UNTIL THE ACCURATE PAYMENT IS RECEIVED BY THE COMPANY OR THEIR REPRESENTATIVE.

PAYMENT INFORMATION

❍ Check: Please make check payable to Ascension Benefits & Insurance Solutions.
Enclosed is check #_____ for $_____

❍ Credit Card: If you are making your payment by credit/debit card, please complete the following:

❍ VISA ❍ MASTERCARD ❍ AMERICAN EXPRESS

Card number: _____

CSC # (card security) code:_____ Expiration date:_____

I authorize Ascension Benefits & Insurance Solutions. to charge my payment to my credit card in the amount of $_____

Print name (as on card): _____

Cardholder signature: _____