# Directors' and Officers' Insurance Application Form

(including Employment Practices Liability Insurance)

Kaliff INSURANCE 100 YEARS 1917–2017
2009 NW Military Hwy • San Antonio, TX 78213
210-829-7634 • Fax: 210-829-7636 • Web: www.kaliff.com

International Festivals & Events Association
IFEA World
2603 W Eastover Terrace • Boise, Idaho 83706
208-433-0950 • Fax: 208-433-9812

**Notice: The policy for which this application is made applies, subject to its terms, only to any "Claim" first made against the "Insureds" during the certificate coverage period.**

The submission of this application does not guarantee coverage. Completion of this application confirms your desire to obtain insurance through Kaliff Insurance. Membership in the IFEA 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. The policy expiration date is one full year from the policy effective date. Please read all inclusive information and application carefully before signing. This is a claims-made coverage.

Name of Organization: _____

Date of Incorporation: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Title: _____

Phone: (  ) _____ Fax No: (  ) _____

E-mail: _____ Web Site: _____

Please provide an overview description of your organization, events and activities: _____

Number of Full-Time Compensated Employees (over 30 hours a week for 12 months): _____

Number of Part-Time Compensated Employees (under 30 hours a week or less than 12 months): _____

Number of Volunteers: _____ Is the organization a not-for-profit entity? ❍ YES ❍ NO

Tax ID No.: _____ Does the Organization have any Subsidiaries? ❍ YES ❍ NO

If YES, please define further: _____

## FINANCIAL INFORMATION

Organization's Annual Income: $_____ Organization's Total Assets from Balance Sheet: $ _____

Organization's Total Liabilities from Balance Sheet: $_____

**Note: If more than $5 million for any one category, please submit most recently completed fiscal year financial statements with application.**

Does the organization currently have D&O coverage in force? ❍ YES ❍ NO

If YES, please provide the following:

Carrier: _____

Limit: _____ Premium: _____ Retention: _____ Expiration Date: _____

Desired effective date (Check One):

❍ Start my coverage on the date my application and payment are received.

❍ Start my coverage on this date: _____

**Note: Coverage will not be made effective prior to the date that the application and payment are received and approved by Kaliff Insurance.**

## 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 loss payment and defense costs):

❍ If so, check here and explain: _____

_____

_____

_____

❍ 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 so, check here and explain: _____

_____

_____

_____

## PREMIUM CALCULATION

If your organization meets the underwriting criteria for the program, limits of liability will be available based upon your organization's annual income.

Select coverage Option A or B below:

### ❍ OPTION A

Directors and Officers/Employment Practices Liability coverage includes a $1,000,000 limit with a $1,000 retention per claim.

ORGANIZATION'S ANNUAL INCOME

- ❍ Less than $1.5 million
- ❍ $1.5 - $3 million
- ❍ $3 million - $5 million

### ❍ OPTION B

Directors and Officers/Employment Practices Liability coverage includes a $2,000,000 limit with a $1,000 retention per claim.

ORGANIZATION'S ANNUAL INCOME

- ❍ Less than $1.5 million
- ❍ $1.5 - $3 million
- ❍ $3 million - $5 million
- ☐ $5 million or higher

## OPTIONAL COVERAGE ADDITIONS

As desired, the following optional coverage areas may be added to this policy.

❍ **Outside Directorship Liability** (supplemental information must be completed below).

❍ **Volunteer Worker Medical Payments**. Limit is $10,000 per person.

# of volunteers_____

## OUTSIDE SERVICE / DIRECTORSHIP COVERAGE SUPPLEMENTAL (NOT-FOR-PROFIT ENTITIES ONLY)

**Note: To be completed only if Optional Coverage Addition is selected.**

Name of individual(s) including title(s) or position(s): _____

Name of outside not-for-profit entity/entities and position(s): _____

Nature of outside entity/entities operation: _____

Has the individual been requested by the Insured organization to serve on this outside board: ❍ YES ❍ NO

List the D&O insurance carrier and limit for the outside entity: _____

Has the outside entity incurred any claims in the past 5 years or is it currently under any legal proceeding or investigations? ❍ YES ❍ NO
*If yes, please attach details.*

### Reminder:

- Premiums are 100% fully earned at inception and nonrefundable.
- Coverage can only be obtained by remitting a signed and completed application along with payment in full.
- Incomplete applications will be declined and returned.
- All applications must be signed below by the Board Chair, CEO or Treasurer of your organization.
- Coverage will not be made effective prior to the date that the completed application and payment are received in the Kaliff Insurance office.

## EXPLANATIONS

The following items should be considered with relation to claims-made policies:

### Prior Acts

If a claims-made policy contains a retroactive date, that policy provides no coverage for claims arising out of incidents, occurrences, or alleged wrongful acts which took place prior to that retroactive date.

### Claims-Made During Policy Period

This policy covers only claims actually made or incidents reported against the insured while policy remains in effect, or any applicable extended reporting period. All coverage 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 non-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.

## WARRANTY AND DISCLOSURE 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, and should my figures exceed my estimates during the coverage term I will make arrangements to pay the additional premium. 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 application and understand the exclusions which apply, as well as the activities and operations for which coverage is not provided. The information I provided on this application becomes a part of the insurance contract.

Applicant Signature: _____

Printed name: _____ Title: _____ Date: _____

**(Must be signed by the Board Chair or CEO acting as an authorized agent of the organization)**

**Mail, fax or e-mail completed and signed applications to:**

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