TRAVELERS

Wrap+®

Community Association Management Liability
Coverage Application

Travelers Casualty and Surety Company of America
Travelers Casualty and Surety Company *(only applicable in Guam, Puerto Rico and the Virgin Islands)*

THE INFORMATION BEING REQUESTED IS FOR A CLAIMS-MADE AND REPORTED POLICY. IT IS IMPORTANT THAT YOU READ ALL OF THE PROVISIONS OF YOUR POLICY CAREFULLY.

DEFENSE EXPENSES ARE INCLUDED WITHIN THE LIMITS OF COVERAGE AND RETENTION, AND SUCH LIMITS MAY BE COMPLETELY EXHAUSTED BY THE PAYMENT OF DEFENSE EXPENSES. THE COMPANY WILL NOT BE LIABLE FOR DEFENSE EXPENSES OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT AFTER EXHAUSTION OF THE LIMITS OF COVERAGE.

Answer each question on behalf of all entities seeking insurance coverage, unless specifically requested otherwise.

An Additional Information section is provided at the end of this document for any information that exceeds the space provided.

GENERAL INFORMATION

Proposed First Named Insured & Other Named Insured(s):	Today's Date:
Mailing Address:	
Web Address:	Date Incorporated:

ORGANIZATION INFORMATION

1. Type of association: ☐ Condominium ☐ Cooperative ☐ Homeowner Association ☐ Timeshare/Interval ☐ Commercial/Industrial/Professional

   Are you a master association? ..... ☐ Yes ☐ No
   If yes, for commons area only? ..... ☐ Yes ☐ No

2. Have you or any builder/developer or sponsor associated with you, filed for or contemplated filing for bankruptcy or reorganization pursuant to applicable federal or state law? ..... ☐ Yes ☐ No

EMPLOYEE INFORMATION

3. Please complete the following chart providing the number of full time and part time employees, volunteers and natural person independent contractors:

As of Date of Application		*Previous 12 Months*		*As of Date of Application*	
Full Time Employees	*Part Time Employees*	*Full Time Employees*	*Part Time Employees*	*Volunteers*	*Independent Contractors*

4. If you contract with an independent professional community association manager for management services please complete following information:

   Name of Management Company: _____

   Address: _____ City: _____

   State: _____ Zip Code: _____

COMMUNITY INFORMATION

5. How many units/lots will the community association have upon completion? _____

6. Are there any commercial units? ..... ☐ Yes ☐ No
   If yes, are any of the units:
   Bars or restaurants? ..... ☐ Yes ☐ No

7. Does the builder/developer maintain any representation on your board of directors? ..... ☐ Yes ☐ No

8. The average value of unit/lot is:
   ☐ Less than $1,000,000 ☐ $1,000,000 to $1,999,999 ☐ $2,000,000 or greater

9. Your amenities. Please check all that apply:
   ☐ Country Club ☐ Condo/Hotel ☐ Golf Course ☐ Airport Facilities
   ☐ Marina ☐ Skiing ☐ Horse Facilities ☐ None
   If any of the above are selected, is membership mandatory for all community association residents? .... ☐ Yes ☐ No

FINANCIAL INFORMATION

10. Have you had a negative fund balance within the past 3 years? ..... ☐ Yes ☐ No

11. Are any renovation or improvement projects in progress or are being contemplated in the next 12 months? ..... ☐ Yes ☐ No
    If yes, is the total value of these projects greater than $100,000? ..... ☐ Yes ☐ No

12. Please indicate the percentage of units in arrears over 90 days:
    ☐ Less than 10% ☐ Between 10% and 20% ☐ Greater than 20%

If you meet any of the following criteria, please provide your most recent fiscal year end financial statement:

a. You have requested a limit greater than $2,000,000 for Liability Coverage.
b. You are a cooperative, condo/hotel, or timeshare/interval association.
c. You have an inadequate or negative fund balance.

REQUESTED INSURANCE INFORMATION

13. Requested Limit: $ _____ 14. Requested Retention: $ _____
15. Expiring Limit: $ _____ 16. Expiring Retention: $ _____
17. Expiring Premium: $ _____

18. As of the date you first purchased the coverage, are you or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim being made against them under the coverage for which you are applying? ..... ☐ Yes ☐ No
    If yes, provide details in the Additional Information section at the end of this Application.

With respect to the information required to be disclosed in response to the questions above, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of yours had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy.

PRIOR INSURANCE AND CLAIM HISTORY

19. With respect to the coverage requested in this Application, please provide details or attach a loss run for all previous claims, losses, litigation, or proceedings, whether insured or not, occurring in the past five years that would fall within the scope of any Directors & Officers or Employment Practices insurance products.

20. With respect to the coverage requested, has there ever been any legal action taken by or on behalf of you against any member of yours (excluding liens or collection claims) or against any third party including any builder/developer? ..... ☐ Yes ☐ No

21. With respect to the coverage requested, are there any pending claims, counter-claims or litigation against any person or entity proposed for this insurance? ..... ☐ Yes ☐ No
If yes, please provide the following for each claim:

a. Date of such claim: _____
b. Nature of the claim: _____
c. Amount paid for defense: $ _____
d. Amount sought or paid for damages: $ _____
e. Was the claim covered by insurance? ☐ Yes ☐ No
f. Were corrective procedures implemented? ☐ Yes ☐ No
g. Current status: _____

To enter more information, please provide details in the Additional Information section at the end of this Application.

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website:

http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

This application, including any material submitted in conjunction with the application or any renewal, does not amend the provisions or coverages of any insurance policy or bond issued by Travelers. It is not a representation that coverage does or does not exist for any particular claim or loss under any such policy or bond. Coverage depends on the facts and circumstances involved in the claim or loss, all applicable policy or bond provisions, and any applicable law. Availability of coverage referenced in this document can depend on underwriting qualifications and state regulations.

FRAUD STATEMENTS – Attention Applicants in the Following Jurisdictions:

ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (and willfully in D.C. and MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (and willfully in D.C. and MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: 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.

FLORIDA: Any person who 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.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO AND PENNSYLVANIA: 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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

SIGNATURES

I declare that I have examined this application and accompanying supplements and materials, and to the best of my knowledge and belief, after reasonable inquiry, they are true, correct, and complete, and may be relied upon by Travelers. I understand that if any of this information changes prior to the issuance of the insurance applied for that I am obligated to notify Travelers of such changes and that Travelers may modify or withdraw any proposal for insurance. Travelers is authorized to make inquiry in connection with this application.

Authorized Representative Signature:* (Principal, Officer, or Shareholder) X	Authorized Representative Name - Printed:	Date:
Producer Signature: * X	State Producer License No (required in FL):	Date:

Agency:	Agency Contact:	Agency Phone Number:

* If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance – Authorized Representative

☐ Electronic Signature and Acceptance – Producer

ADDITIONAL INFORMATION

This area may be used to provide additional information to any question. Please reference the question number.