<Company Name>
Mailing Address: P.O. Box 5900, Madison, WI53705-0900

ERISA BOND APPLICATION

Name of Plan(s) *(exact name of Plan(s) to be covered)* _____

_____

Address _____

City _____ State _____ Zip _____ Phone Number (_____) _____ - _____

1. Is the Plan audited annually by a CPA? ☐ YES ☐ NO

   If yes, provide name of the CPA firm _____

   Address _____ City _____ State _____ Zip _____

2. Does an Independent Administrator service the Plan? ☐ YES ☐ NO

   If yes, provide name of Administrator _____

   Address _____ City _____ State _____ Zip _____

Please note Independent Administrators will not be covered under Bond unless you contact your Branch Office.

3. How many trustees are there for the Plan? _____
4. Are two signatures required to withdraw from the Plan? ☐ YES ☐ NO *(If no, submit to your Branch Office for underwriting)*
5. Who reconciles Plan's bank statement? _____
6. Who deposits funds in Plan's accounts? _____

(If the same name is listed in both questions 5 and 6, submit application to your Branch Office for underwriting)

Amount of Bond $ _____

Qualified Plan Assets $ _____ *Bond amount must be for at least 10% of Qualified Plan Assets. Maximum Bond limit is $500,000.*

Non-Qualified Plan Assets $ _____ *Bond amount must be for 100% of the Non-Qualified Plan Assets.*

Premium Basis ☐ 1 Year prepaid ☐ 3 Year Prepaid Proposed Effective Date _____

Is Inflation Guard Coverage desired? ☐ YES ☐ NO

Please call the Branch Office for Authorization on Bonds over $100,000.

READ CAREFULLY AND SIGN

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

The individuals and/or organizations indicated below hereby agree that any electronic signatures (including facsimile signatures) utilized in connection with the execution of this document shall be considered originals and be fully binding and enforceable. Further, the use of any electronic signature by a party shall be evidence of that party's intent to be bound to the terms of such document. The parties agree that they shall not raise any defense (statutory or otherwise) to the enforceability of this document based upon the fact an electronic signature has been used.

FRAUD STATEMENT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY 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 MAY SUBJECT THAT PERSON TO CRIMINAL AND/OR CIVIL PENALTIES. PENALTIES MAY INCLUDE CONFINEMENT IN PRISON, FINES AND DENIAL OF INSURANCE BENEFITS.

Signed at _____

Insured: _____

This _____ Day of _____ , _____ By: _____
(Signature) Trustee (Title)

SUBMITTING AGENT'S INFORMATION:

Name: _____ License Number: _____

Mailing Address: _____

Phone: _____ Contact: _____

Underwriting Service Office Address:
<Service Office Location>