

Fiduciary Liability Application

NOTICE:

THIS POLICY IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

INSTRUCTIONS

Instructions for the **Educational Institution** (applicant):

- § Please complete all portions of this Supplemental Application completely, truthfully, and accurately.
- § This application may be completed electronically using the fillable fields. To save a partially-completed PDF application and send it someone else, save it as PDF to your hard drive or desktop and attach it to an email, or use the “send” function in Adobe Reader. Be sure to include any attachments.
- § Print the PDF and sign the application. Scan the completed form and save it to your desktop or hard drive.
- § Email the completed and signed application with all necessary attachments to your broker.
- § If you do not understand a question, please have your broker contact United Educators (UE) for clarification.

Submitting Broker

Please complete the information below. Confirm that all application questions are answered and that the application is signed before submitting it to UE.

Submitting Broker Must Complete	Send completed application to:
Person to Contact:	applications@ue.org OR Fax: (301) 907-8620 United Educators 7700 Wisconsin Avenue Suite 500 Bethesda, MD 20814 Phone: (301) 907-4908
Address 1:	
Address 2:	
Phone Number:	
Email:	
License Number:	

APPLICATION

Full Legal Name and Address of the Educational Institution	
Institution Name:	
Address 1:	
Address 2:	
City, State, & Zip:	

The undersigned is an authorized representative of the **Educational Institution** and all persons or concerns applying for Fiduciary Liability coverage. The undersigned declares that all information provided is complete, truthful, and accurate.

Signature: _____ Date: _____

Name: _____

Title: _____

Educational Institution: _____

The signing and submission of this application does not bind United Educators to issue, or the **Educational Institution** to purchase, any specific policy or coverage. The information provided in this application is for underwriting purposes only, and does not constitute notice to United Educators of a claim or potential claim under any policy.

A. FIDUCIARY LIABILITY

Subject to underwriting requirements, United Educators can provide coverage for errors or omissions in the administration of benefit programs and/or liability arising out of a violation of the Employee Retirement Income Security Act of 1973 (ERISA). Please complete this form for a quotation for this option.

	Yes	No
1. Did you in the past two years, or do you plan in the next year, to terminate or add any benefit plan or substantially modify or reduce benefit plans?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you:		
a. Self-insure or self-fund any portion of your medical, life, accident, or disability benefit plans (including any employer-funded self-insured retention or deductibles)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Maintain any "defined benefit" retirement plans?	<input type="checkbox"/>	<input type="checkbox"/>
c. Maintain, operate, or control any pension trust?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are any of your retirement or pension plans multiple employer plans or trusts, i.e., offered jointly with other employers (Note: TIAA is not a multiple employer plan)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are any benefit plan premium payments or contributions not current?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently have:		
a. Employee benefits "administrative error" coverage in your primary CGL policy?	<input type="checkbox"/>	<input type="checkbox"/>
b. An ERISA policy (If YES, provide name of insurer, limit, retention, and premium)?	<input type="checkbox"/>	<input type="checkbox"/>

B. FIDUCIARY LIABILITY—SCHEDULE OF BENEFIT PROGRAMS

Each benefit program for which you are requesting coverage must be scheduled below.

Benefit Plan Name: _____ Year Plan Established: _____

Description of Plan (type of plan, eligibility to participate, method of funding):

	Yes	No
1. Form 5500 filed?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, is a copy of 5500 attached to application?	<input type="checkbox"/>	<input type="checkbox"/>
2. Who administers this Benefit Plan?		
<input type="checkbox"/> Educational entity		
<input type="checkbox"/> Insurance company		
<input type="checkbox"/> Bank/trust company		
<input type="checkbox"/> Other third party administrator		
Name: _____		
	Yes	No
If Benefit Plan is administered by the Educational Institution :		
a. Is Plan unfunded (i.e., treated as an operation expense)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Is Plan funded (reserve fund, restricted account, self-insurance fund, trust)?	<input type="checkbox"/>	<input type="checkbox"/>

If Benefit Plan is *administered by the Educational Institution*, please complete the following schedule for the **last three years**:

Year	Number of Participants	If <i>Unfunded</i> , Annual Amount Expended (\$)	If <i>Funded</i> , Annual Contributions or Transfers (\$)	If <i>Funded</i> , Total Plan Assets (\$)

PLEASE DUPLICATE PAGE AND/OR ATTACH ADDITIONAL SHEETS AS NEEDED