



FIDUCIARY LIABILITY –ESOP Questionnaire

Name of Insured/Applicant: _____ *Date:* _____

Date ESOP established? _____

Reasons/purpose for establishing ESOP (i.e. anti-takeover, employee benefit, owner cashout, etc)

Were any benefit plans terminated upon establishment of the ESOP? Yes ___ No ___
If yes, provide details regarding distribution of assets, notice and acceptance by participants, rollover to ESOP, and impact to other plan benefits:

Was there any dissident reaction/action by employees, shareholders, or plan participants upon establishment of the ESOP? Yes ___ No ___

If yes, provide details: _____

Dollar Value of ESOP \$ _____

Total Shares held by ESOP _____

What Percentage of the Insured/Applicant is owned by ESOP?

Shares _____

Dollar Value \$ _____

Number of shares: allocated _____ *unallocated* _____

Who votes unallocated shares? _____

What, if any, are the pass-through voting provisions?

Is there employee representation on the board? Yes ___ No ___

If so, how many seats do ESOP participants hold? _____

What are the requirements regarding entry and exit of plan, (i.e.) cashout, retain shares, transfer, etc.. :

What is the vesting requirement for ESOP shares allocated? _____

Is the ESOP leveraged? Yes _____ No _____

If yes, provide information regarding amount borrowed, financing terms, balances due and how loan will be repaid:

Is there an independent appraisal/valuation report provided reflecting the fair market value of the common shares held by the ESOP? Yes _____ No _____

Do we have a copy of the appraisal/valuation report? Yes _____ No _____

Who performed the appraisal/valuation? _____

Plan Trustees: _____

Plan Administrators: _____

Plan Legal Counsel: _____

RUSSELL BOND & Co., INC.

PENSION AND WELFARE BENEFIT PLAN FIDUCIARY LIABILITY INSURANCE APPLICATION

NOTICE: THE POLICY FOR WHICH APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS, ONLY TO ANY "CLAIM" FIRST MADE OR DEEMED MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE POLICY PROVIDES THAT THE LIMIT OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY "DEFENSE EXPENSES", AND THAT "DEFENSE EXPENSES" SHALL BE APPLIED AGAINST THE RETENTION.

1. a) Name of Sponsor Organization: _____
- b) Principal Address: _____
- c) Is the Sponsor Organization a:
 - Single Employer Governmental Employer Multiple Employer
 - Other (for example, Church): _____
- d) Name and title of the officer of the Sponsor Organization who will be the Insurance Representative designated as the exclusive agent to act on behalf of the Insureds, individually or collectively, in all matters relating to this insurance:

2. Limit desired: _____

3. Will funds from the Plan be used to purchase insurance? Yes No

If "Yes", is it understood that the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, allows the Insurer to seek recourse against Insureds under certain circumstances, and that the insurance policy herein applied for will contain such a recourse provision? Yes No

4. Complete the following for all Plans. Attach a schedule, if necessary.

Under Status, insert the appropriate letter:

Under Type, insert the appropriate number:

- A. Benefits exclusively from insurance or annuity contracts
- B. Investments by bank or trust company
- C. Investment Manager appointed (ERISA 402(c)(3))
- D. Investments under Plan or sponsor control

- 1. Defined Benefit
- 2. Defined Contribution
- 3. Welfare
- 4. Other (specify)

Plan Name	Status	Reporting Year	Asset Value	Type	Contributions	Number of Participants

PLEASE ATTACH LATEST FORM 5500s, INCLUDING ALL APPLICABLE SCHEDULES, AND CURRENT AUDITED FINANCIAL STATEMENTS FOR EACH PLAN.

5. If any Plan listed in the schedule on the preceding page is an Employee Stock Ownership Plan, please fill in the following. Otherwise, proceed to Question 6.

- a) Plan name: _____
- b) When was the Plan established? _____
- c) What percentage of the Sponsor Organization's common stock is held by the Plan? _____
- d) If the stock is not publicly traded on an exchange, how is the stock valued? _____
- e) How often is the stock valued? _____

6. If any benefits are from insurance/annuity contracts, please fill in the following. Otherwise, proceed to Question 7.

- a) Plan name: _____ Insurance carrier: _____
- b) Plan name: _____ Insurance carrier: _____

7. Have procedures been adopted to ensure that each Plan is administered according to its terms, and that it complies in form and operation with ERISA, the Internal Revenue Code of 1986, and other applicable laws and regulations? Yes No

8. Please answer the following questions, and explain by attachment to this Application any "Yes" answer.

- a) Has any Plan filed for exemption from a prohibited transaction? Yes No
- b) Does any Defined Benefit Pension Plan have a funding deficiency? Yes No
- c) Has the Internal Revenue Service withdrawn or threatened to withdraw the tax-exempt status of any Plan? Yes No
- d) Does any Plan hold employer securities or employer real property in violation of ERISA or in excess of amounts permitted by ERISA? Yes No
- e) Is any Plan loan, lease or debt obligation in default or classified as uncollectible? Yes No
- f) Has any Plan received an adverse opinion as to its financial condition by an independent public accountant? Yes No
- g) Has any person acting as a fiduciary of any Plan been:
 - i) accused or found guilty of a breach of trust? Yes No
 - ii) accused or found guilty under any criminal act enumerated in Section 411 of ERISA? Yes No
 - iii) refused coverage under a fidelity bond? Yes No

9. a) In the past 36 months has a merger, transfer of assets or termination of a Plan (or Plans) been completed or agreed to? Yes No
 If "Yes", please explain in detail. _____

b) Is any merger, transfer of assets or termination of a Plan (or Plans) expected within the next 12 months? Yes No
 If "Yes", please explain in detail. _____

10. Please list all Plan trustees who are directors, officers and/or employees of the Sponsor Organization:

Name	Title or Occupation	Date Appointed as Trustee
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Has the fiduciary or fiduciaries of any Plan delegated authority for the management and control of such Plan's assets to any outside consultant(s)? Yes No

If "Yes", please explain and provide the following information with respect to each Plan (attach supplemental schedule, if necessary):

Type of Consultant	Name and Address	Years Employed
Investment Advisor	_____	_____
Actuary	_____	_____
Legal Counsel	_____	_____
CPA	_____	_____
Administrator	_____	_____
Other(s)	_____	_____

12. During the past three years, has any consultant other than the consultant(s) identified in the answer to Question 11 above been delegated any authority for the management and control of any Plan's assets? Yes No
 If "Yes", please explain circumstances. _____

13. Does the Sponsor Organization have a financial, equity or other interest in any consultant identified in the answer to Question 11 above, or is any such consultant a director, officer and/or employee of the Sponsor Organization? Yes No
 If "Yes", please explain. _____

14. a) No claims have been made against any person proposed for this insurance in his/her capacity as a fiduciary of any Plan, except as follows (include loss payment and defense costs. If answer is "None", so state):

b) No person or entity proposed for this insurance has any knowledge or information of any fact, circumstance or situation which might reasonably give rise to any claim that would fall within the scope of the proposed insurance, except as follows (if answer is "None", so state):

Without prejudice to any other rights and remedies of the Underwriter, any claim arising from any fact, circumstance or situation required to be disclosed in response to Questions 14. a) and 14. b) is excluded from the proposed insurance.

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT, TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. ACCEPTING THIS APPLICATION DOES NOT BIND THE UNDERWRITER TO COMPLETE THE INSURANCE.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE UNDERWRITER AND ALONG WITH THE APPLICATION IS CONSIDERED PHYSICALLY ATTACHED TO THE POLICY. THE UNDERWRITER WILL HAVE RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING ANY POLICY. THIS APPLICATION WILL BECOME A PART OF SUCH POLICY IF ISSUED.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE UNDERWRITER, WHO MAY MODIFY OR WITHDRAW ANY QUOTATION.

THE UNDERSIGNED DECLARES THAT THE PERSON(S) OR ENTITY(IES) PROPOSED FOR THIS INSURANCE UNDERSTAND:

- (A) THIS POLICY APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD", OR, IF PURCHASED, ANY EXTENDED REPORTING PERIOD.
- (B) THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS ~~IS~~ ~~WE~~ REDUCED BY "DEFENSE EXPENSES", AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION.

NOTICE TO NEW YORK APPLICANTS: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO MINNESOTA AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SPONSOR ORGANIZATION		
BY (Insurance Representative Signature)	TITLE	DATE

NOTE: This Application must be signed by the Insurance Representative of the Sponsor Organization acting as the authorized agent of the persons and entities proposed for this insurance.

PRODUCED BY (Insurance Agent)	INSURANCE AGENCY
INSURANCE AGENCY TAXPAYER I.D. OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS (No., Street, City, State, and Zip Code)	

SUBMITTED BY (Insurance Agency)	INSURANCE AGENCY TAXPAYER I.D. OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS (No., Street, City, State, and Zip Code)		