

**RENEWAL APPLICATION**

**CLAIMS MADE WARNING FOR APPLICATION**

**THIS PROPOSAL FORM IS FOR A CLAIMS MADE AND REPORTED POLICY, RELATING TO CLAIMS MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.**

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the **Policy**. This Proposal Form is to be completed with respect to the entire Insured Entity. **Insured Entity (Franchisor)** as used herein is defined to include the **Named Insured** and any **Subsidiaries**.

All Applicants must complete Sections: A, B, C, D, F Provide details to all "Yes" answers, when applicable, by attachment.

**Franchisee(s)** information (except under Section E) is not to be included in answers unless owned by the **Named Insured**.

**Section A:**

Name of **Named Insured**

Street Address

Suite

City

County

State

Zip Code

Website Address (if applicable)

Federal Employer Identification Number (FEIN)

The Officer designated as agent of the **Insured Entity** and of all **Insureds** to receive any and all notices from the **Insurer** or their authorized representatives concerning this insurance:

Contact Name

Title

E-mail Address

Telephone Number

Fax Number

**Producer Information**

Submitted by (Agency Name)

Dated

Agent's Name (Individual's Name)

Agent's License Number

**Section B. Current Franchisor Insurance Information** (Provide details to all "Yes" answers by attachment)

- 1. Within the last 3 years, has any **Claim** been made or has notice been given under any of the previous policies for Directors and Officers Liability, Employment Practices Liability, Franchise Errors & Omissions/ Professional Liability or Fiduciary Liability insurance or similar insurance?  Yes  No

**Section C: General Information** (Provide details to all "Yes" answers by attachment)

- 1. (a) Form of organization:
 

<input type="checkbox"/> Cooperative	<input type="checkbox"/> Corporation	<input type="checkbox"/> Joint Venture*
<input type="checkbox"/> Limited Liability Corporation	<input type="checkbox"/> Nonprofit	<input type="checkbox"/> Partnership*
<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other:	

\*If a Partnership or Joint Venture, provide participation or ownership structure details by attachment.

- (b) Type of organization:
 

<input type="checkbox"/> Manufacturing / Production	<input type="checkbox"/> Public Administration	<input type="checkbox"/> Retail Trade
<input type="checkbox"/> Service Industry	<input type="checkbox"/> Web Based	<input type="checkbox"/> Wholesale Distributing

2. Is the **Named Insured, any Subsidiary publicly held**, or a public reporting company under the Securities Exchange Act of 1934?  Yes  No

3. Provide the following financial information with respect to the **Insured Entity**:

Assets (000): \_\_\_\_\_ Annual Revenues (000): \_\_\_\_\_ Total Number of **Employees\***: \_\_\_\_\_  
 Equity (000): \_\_\_\_\_ Operating Income / Loss \_\_\_\_\_ Period Ending: \_\_\_\_\_

**\*Franchisor Only**

4. (a) Is the **Insured Entity** currently in bankruptcy?  Yes  No

(b) Within the next 12 months, is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code?  Yes  No

5. (a) Within the last 12 months, has the **Insured Entity** had any **Subsidiary**, plant, facility, branch or office closings, consolidations or layoffs?  Yes  No

(b) Within the next 24 months, does the **Insured Entity** anticipate any **Subsidiary**, plant, facility, branch or office closings, consolidations or layoffs?  Yes  No

If "Yes", provide the following details by attachment: Date of event; number of **Employees** affected; whether outside Employment counsel was consulted; and, whether severance packages were offered to all **Employees** affected.

6. Within the last 12 months, has there been any change (resignations, departures, retirements, etc.) in the position of the Chairman of the Board, President, Chief Executive Officer, or Chief Financial Officer?  Yes  No

If "Yes", provide the following details by attachment: Name of individual, date of change, and reason for change.

7. Any New Subsidiaries? If "None", so state.  None

8. Subsidiary List

Subsidiary Name	Nature of Business	Percent* Owned by the Insured Entity	Date Created or Acquired	Domestic / Foreign
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

9. During the last 12 months, has the **Insured Entity** or any of the **Insured Persons** received any written demands for monetary or non-monetary relief, been involved in, or had any knowledge of any civil or criminal action, administrative or  None

(a) any intellectual property disputes, including Copyright, Patent, or Trademark Laws?  Yes  No

(b) any alleged violation of any Federal or State Security Law or Regulation?  Yes  No

(c) any alleged violation of any Federal or State Anti-Trust or Fair Trade Law?  Yes  No

(d) any other allegations of violations of federal, state or local statute, regulation, ordinance or common law that would otherwise be within the scope of this proposed insurance?  Yes  No

10. Provide the name of the law firm(s) used for general business affairs: \_\_\_\_\_

**IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES IN QUESTION 8. UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED.**

**IF "YES" TO ANY PART OF QUESTION 9., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:**

(a) Date Claim first made (b) Claimant's Name (c) Allegation (d) Current Status  
 (e) Demand Amount (f) Settlement (Indemnity) or Reserve Amount (g) Attorney's fees

**IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTION 9.**

**Section D: Directors, Officers and Corporate Liability Insurance Coverage Section Information**

1. Provide the following information regarding the **Insured Entity's** outstanding ownership:
- |   |  |                        |
|---|--|------------------------|
|   | <u>Common Stock /<br/>Membership Units</u>               | <u>Preferred Stock</u> |
| (a) Total number of shares or units outstanding:  |  |                        |
| (b) Total number of security holders:   |  |                        |
| (c) Number of shares or units owned directly and/or beneficially by the <b>Insured Persons</b> :  |  |                        |
| (d) Does any security holder own, or have the right to own, directly and/or beneficially, 5 percent or more of the <b>Insured Entity's</b> outstanding shares or units?<br>If "Yes", provide the following information: | <input type="checkbox"/> Yes <input type="checkbox"/> No |                        |
- |   |   |  |
|---|---|--|
|   | <u>Percent Owned by<br/>Security Holder</u> | <u>Represented on the <b>Insured Entity's</b> Board<br/>of Directors or Board of Managers?</u> |
| <u>Name of Security Holder<br/>(including individual and corporate names)</u> |   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       |
|   |   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       |
|   |   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       |
|   |   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       |
|   |   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       |
|   |   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       |
2. Within the last 12 months, has the **Insured Entity** been involved in, or is it presently considering, any sale of its stock (in excess of 10 percent of the total stock outstanding), repurchase of its stock, merger, consolidation, acquisition, tender offer, private placement, or divestment? If "Yes", complete (a), (b) and (c) below:
- (a) Is this with respect to a Registration Statement for a public offering of securities within the next 12 months?  Yes  No  
If "Yes", attach the prospectus including all amendments thereto, or describe below if prospectus is unavailable.
- (b) Is this with respect to funds being generated by venture capital or private placement funding?  Yes  No  
If "Yes", describe: \_\_\_\_\_
- (c) If "No", for (a) and (b) above, provide the following details below: Description of referenced transaction; date or anticipated date of transaction; and any other appropriate details: \_\_\_\_\_
3. Who is the current accounting firm retained by Named Insured: \_\_\_\_\_
- (a) In the last 12 months has Named Insured changed accounting firms?  Yes  No

**Section E: Employment Practices Liability Insurance Coverage Section Information**

(OPTIONAL COVERAGE)

1. **Number of Employees:**
- |                      | Full Time | Part Time | Leased | Employees located in CA | Volunteers and/or Interns | Independent Contractors | Annual Turnover Rate |
|----------------------|-----------|-----------|--------|-------------------------|---------------------------|-------------------------|----------------------|
| <b>Current Year:</b> |           |           |        |                         |                           |                         |                      |
| <b>Last Year:</b>    |           |           |        |                         |                           |                         |                      |
2. What percentage of the **Insured Entity's Employees** currently earns more than \$100,000? \_\_\_\_\_%
3. Does the **Insured Entity** (details to "Yes" or "No" answers are not required by attachment):
- (a) In the last 12 months has Named Insured changed accounting firms?  Yes  No
- (b) Require the Human Resource Department to review and approve each proposed **Employee** termination?  Yes  No
- (c) Have outside employment counsel review each proposed **Employee** termination?  Yes  No
- (d) Maintain a written policy prohibiting Sexual Harassment and distribute that policy to all **Employees**?  Yes  No
- (e) Conduct mandatory periodic **Employee** education regarding prohibited forms of harassment?  Yes  No
- (f) Periodically have its employment policies and procedures reviewed by outside employment counsel?  Yes  No
- (g) Periodically have its employment policies and procedures distributed to all **Employees**?  Yes  No
- (h) Have a written procedure for notification and handling of employment related grievances, disputes, notifications, or claims?  Yes  No

4. Indicate which formal written policies and procedures have been implemented and attach a copy of each. If "None", so state.
- None
- Employee Handbook / Manual       Anti-Harassment Policy, including Sexual Harassment      Employers with more than 50 Employees
- Anti-Discrimination Policy – Equal Opportunity Employment (EEO) Policy       Adherence to Employment "at-will" relationship with all **Employees**       Family Medical Leave Act California Employers Only
- California Family Rights Act
5. During the last 12 months, has any **Insured** known of, or been involved in any lawsuit, charges, inquiries, investigations, grievances or other administrative hearings or proceedings before any of the following agencies and/or in any of the following forums, including both domestic or foreign equivalents?
- (a) National Labor Relations Board?       Yes  No
- (b) Equal Employment Opportunity Commission? **Employee** termination?       Yes  No
- (c) Office of Federal Contract Compliance Programs?       Yes  No
- (d) U.S. Department of Labor? **Employees**?       Yes  No
- (e) Any state or local government agency such as the Labor Department or fair employment agency? harassment?       Yes  No
- (f) U.S. District or state court? Employment counsel?       Yes  No
6. During the last 12 months, has any current or former **Employee** or third party made any **Claim**, or otherwise alleged discrimination, harassment, wrongful discharge and/or **Wrongful Acts** against any **Insured**?       Yes  No
- Note: A **Claim** is not limited to the filing of a lawsuit or complaint with the Equal Employment Opportunity Commission or similar state or local agency. A **Claim** may also include a written demand by any current or former **Employee** seeking relief in connection with an employment-related dispute or grievance.
7. Provide the name of the law firm(s) used for employment related issues and consulted on employee handbook: \_\_\_\_\_

**Section F: Franchisor Errors & Omission Liability:**

1. (a) Number of Franchisee(s) / Locations
- |                   | Owned | Franchised | Closed | Avg. Length / | Turnover Rate/12 Mos. |
|-------------------|-------|------------|--------|---------------|-----------------------|
| Last Fiscal Year: |       |            |        |               |                       |
| This Fiscal Year: |       |            |        |               |                       |
| Next Fiscal Year: |       |            |        |               |                       |
- (b) Does any individual or entity own 10% or more of the Franchisees?       Yes (provide details)  No
2. (a) Initial franchise fee: \_\_\_\_\_ Last Fiscal year: \_\_\_\_\_ Current Fiscal Year: \_\_\_\_\_, Next Fiscal \_\_\_\_\_
- (b) Are royalty/marketing fees percentage of sales or fixed amount: \_\_\_\_\_ If percentage, amount of gross revenue: \_\_\_\_\_
- (c) Does initial franchise fee include (check all that apply):
- Training (initial)       Secure Territory       Application       Secure Solely Location       Location Blueprint/Design
3. Do you conduct **Franchisee(s)** surveys?       Yes  No      If yes, frequency: \_\_\_\_\_ (attach most recent results)
4. Do you utilize "business brokers" to solicit potential **Franchisee(s)**?       Yes  No      (if yes attach list of top ten)
5. (a) Do you have a Franchise Advisory Council?       Yes  No      If yes, What is frequency of meetings: \_\_\_\_\_
- (b) Do you take any disciplinary action or recommend disciplinary action as a result of review group activities?       Yes  No (if yes, attach details)
6. Do you have a franchisee purchasing corp. or any group purchase program?       Yes  No (if yes, attach details)
7. (a) What states has Named Insured filed a FDD in the last 12 months? (attach list)
- (b) Any rejections?       Yes  No (if yes, explain) \_\_\_\_\_
8. (a) Do you promote, sponsor, advise or provide any form of insurance to your Franchisee(s)?       Yes  No (if yes, attach details)
- (b) Do you require Franchisee(s) to carry insurance?       Yes  No (if yes, provide requirements.) \_\_\_\_\_
- (c) How do you ensure compliance? \_\_\_\_\_
- (d) Does Named Insured receive any compensation from vendors that supply Franchisee(s)?       Yes  No (if yes, explain) \_\_\_\_\_

9. (a) Provide the name of the law firm(s) used for franchise agreements, franchise registration/disclosure and/ or **Franchisee(s)** disputes for the last 12 months:  
 (b) If relationship with law firm is less than 3 year who was previous firm: \_\_\_\_\_  
 (c) Reason for change?
10. On a separate document describe the process for selecting and qualifying prospective franchisees.  
 (a) Is there a minimum net worth requirement?  Yes  No  
 (b) Experience requirement?  Yes  No
11. Explain the degree, timing, frequency and details of the Franchisor's training program to its **Franchisee(s)** and cost involved and if mandated.  
 \_\_\_\_\_  
 \_\_\_\_\_

**Section G: Fiduciary Liability Insurance Coverage Section Information (OPTIONAL COVERAGE)**

1. Provide the following information regarding each employee welfare benefit plan, employee pension benefit plan or pension plan, as defined by ERISA, (hereinafter referred to as **Employee Benefit Plan(s)**) which the **Insured Entity** maintains or to which it contributes.

Name of Plan	Type of Plan*	Name of Plan Sponsor	Number of Plan Participants	Annual Contributions	Fair Market Value of Plan Assets
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

\*Type of Plan: (DB)=Defined Benefit; (DC)=Defined Contribution; (ESOP)=Employee Stock Ownership Plan; (WB)=Health & Welfare Benefit; (MEP)=Multi Employer Plan or Multiple Employer Plan; Excess Benefit or Top Hat (EB); (O)=Other

2. Has any employee pension benefit plan or pension plan invested in securities of the **Insured Entity**? If "Yes", provide the following details by attachment: number of shares; cost of shares to the plan; fair market value of shares.  Yes  No
3. Has any employee pension benefit plan or pension plan invested in more than 10 percent of any entity (other than the **Insured Entity** or a pooled investment vehicle such as a mutual fund)? If "Yes", provide name of entity and amount of investment.  Yes  No
4. Has any **Employee Benefit Plan** loaned or pledged any **Employee Benefit Plan** assets to any party-in-interest (including the **Insured Entity**)? If "Yes", provide details by attachment.  Yes  No
5. Are any defined benefit plans under funded by more than 20 percent? If "Yes", provide details by attachment.  Yes  No
6. Are there any overdue employer contributions for any plan, or has any plan requested or contemplated filing a request for a waiver of contributions? If "Yes", provide plan name and amount of overdue contributions by attachment.  Yes  No
7. Within the last 12 months, has there been, or is there currently under consideration, any restructuring, spin-off, transfer, consolidation, merger, termination or other similar transaction of any **Employee Benefit Plan**? If "Yes", provide the following details of the transaction by attachment: whether assets have been fully distributed, date or expected date of any transfer of employees or **Employee Benefit Plans**; copies of any materials relating to the transaction that were distributed to employees or filed with government agencies.  Yes  No
8. If any of the following questions are answered "No", provide details by attachment.  
 (a) Are all **Employee Benefit Plans** compliant with the Health Insurance Portability and Accountability Act ("HIPAA")?  Yes  No  
 (b) Does the plan sponsor comply with the summary plan description requirements under ERISA for all **Employee Benefit Plans**?  Yes  No  
 (c) Do all employee pension benefit plans or pension plans have a written investment policy?  Yes  No  
 (d) Are all employee pension benefit plan or pension plan assets managed by a third party investment manager?  Yes  No  
 (e) Do the fiduciaries review the investment guidelines used by the investment managers at least annually?  Yes  No  
 (f) Is the "fair market value" of all employee pension benefit plan or pension plan assets calculated at least annually?  Yes  No
9. During the last 12 months, has there been, or is there currently, any investigation by the IRS, Department of Labor ("DOL"), Pension Benefit Guarantee Corporation ("PBGC"), or any other state or federal agency of any **Employee Benefit Plan** or any current or former fiduciary of such **Employee Benefit Plan**? If "Yes", provide details by attachment.  Yes  No
10. During the last 12 months, has any **Insured** been named as a party in any civil or criminal action, administrative, arbitration, regulatory or investigative proceeding, or received any other written demands for money or services that would be within the scope of this proposed insurance?  Yes  No

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR EMPLOYEE BENEFIT PLAN(S) IN QUESTION 1. FOR WHICH THE ABOVE INFORMATION IS INCOMPLETE OR NOT PROVIDED

IF "YES" TO ANY PART OF QUESTIONS 10., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

(a) Date Claim first made	(b) Claimant's Name	(c) Allegation	(d) Current Status
(e) Demand Amount	(f) Settlement (Indemnity) or Reserve Amount		(g) Attorney's fees

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTION 10.

## Prior Knowledge Information

1. Is any Insured aware of any actual or alleged act, error, omission, fact, or circumstance or situation involving any Insureds that might reasonably be expected to result in a Claim as defined in each Coverage Section applied for?  Yes  No

IF "YES" TO QUESTION 1., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

(a) Date Claim first made	(b) Claimant's Name	(c) Allegation	(d) Current Status
(e) Demand Amount	(f) Settlement (Indemnity) or Reserve Amount		(g) Attorney's fees

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTION 1.

**NOTICE TO COLORADO APPLICANTS:** 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

**NOTICE TO NEW MEXICO, 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 APPLICANTS OF KENTUCKY:** ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

**NOTICE TO APPLICANTS OF MINNESOTA, NEW JERSEY, OHIO, AND OKLAHOMA:** ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO MAINE, , TENNESSEE, VIRGINIA, AND WASHINGTON APPLICANTS:** 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.

**NOTICE TO APPLICANTS OF 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.

**NOTICE TO ARKANSAS, Warning: It is a crime, see page 7 on canopy app, LOUISIANA, MARYLAND, AND RHODE ISLAND APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

**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**

**Please Read Carefully**

The undersigned, acting on behalf of all **Insureds**, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each and every **Insured** proposed for this insurance to facilitate the proper and accurate completion of this Proposal Form.

The undersigned agree that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and are the basis of the insurance contract. The undersigned further agree that the Proposal Form and any material submitted herewith shall be considered attached to and a part of the **Policy**. Any material submitted with the Proposal Form shall be maintained on file (either electronically or paper) with the **Insurer** and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the **Policy** inception date, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any **Policy**, if issued, will be in reliance upon the truth of such representations; provided, however, with respect to such statements and representations, no knowledge or information possessed by any **Insureds** shall be imputed to any other **Insureds**. If any person or persons knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons. However, if the Chairperson of the Board of Directors, President, Chief Executive Officer, or Chief Financial Officer of the **Insured Entity** knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, then this **Policy** will be void as to that person or persons and the **Insured Entity**; this Proposal Form has been completed as respects the entire **Insured Entity**; the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

Date	President, Chief Executive Officer, Chief Financial Officer, or equivalent position (Signature)
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Date	Human Resources Manager, or equivalent position (Signature)
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This Proposal Form, including any material submitted herewith, shall be held in strictest confidence.  
**A POLICY CANNOT BE ISSUED UNLESS THE APPLICATION IS PROPERLY SIGNED AND DATED.**

Please submit this Proposal Form including appropriate documentation to:

**National Exclusive Agent:**

**FranchisePerils**

A division of ExecutivePerils, Inc.

800 Wilshire Blvd, Suite 1525, Los Angeles, CA 90017

[www.franchiseperils.com](http://www.franchiseperils.com)

(310) 444-9333

LIC# 0E36308

Please forward in hard copy the following items along with a completed, signed, and dated application:

- Franchise Disclosure Document (FDD) Franchise Agreement
- Current Litigation Schedule (Not in FDD) Most Recent Financial Statement
- Employee Handbook (if seeking Employment Practices) Copy of most recent 5500s (if seeking Fiduciary Liability)
- Schedule of all current franchisees listed by state.
- Schedule of franchisees currently in default under their franchise agreements and type of default.
- Copy of operating manual and/or similar materials table of contents