



Identify Fraud Expense Reimbursement Coverage Application

APPLICATION

Travelers Casualty and Surety Company of America
Hartford, Connecticut 06183

GENERAL INFORMATION

The term "Applicant" means all corporations, organizations or other entities, including subsidiaries, whose employees are to be covered under this insurance.

Table with 4 columns: Agency, Code, Agent Name/License Number, Policy Number

Name of Applicant:
Street Address:
City, State, Zip:
Website Address:
Description of Applicant's Operations:
Number of Employees Proposed for this Insurance:

Table with Requested Limit, Requested Retention, Expiring Limit, Expiring Retention and Requested Effective Date columns.

LOSS INFORMATION

- 1. Has the Applicant experienced, in the last three years, a theft or loss of employee, customer or member information?
2. Is the Applicant currently aware of any situation that may cause a loss under this policy?

CONTACT INFORMATION*

Contact Name:
Email:
Phone:

*Contact information required to verify employment at time of claim.

SIGNATURE SECTION

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED IN CONNECTION WITH THE APPLICATION PROCESS, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Attention: Insureds in AR, CO, DC, FL, KY, LA, ME, NJ, NM, NY, OH, OK, PA, TN, and VA

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 may also be subject to a civil penalty.

(In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation.)

(In Colorado, 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.)

(In 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 or concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.)

(In 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.)

Signature of **Applicant's** Authorized Representative (President or CEO): _____ Title: _____

Name (Printed): _____ Date: _____

ADDITIONAL INFORMATION

This page may be used to provide additional information to any question on this application. Please identify the Section and Question Number (e.g., Loss Information, #2).