

The Cincinnati Insurance Company

PILLAR POLICY RENEWAL APPLICATION FOR NONPROFIT ORGANIZATIONS

(other than Community Associations, Healthcare Institutions & Educational Institutions)

THIS POLICY PROVIDES CLAIMS-MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. TO THE EXTENT IT IS NOT OTHERWISE INDICATED, THE LIMIT OF INSURANCE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY DEFENSE COSTS, AND DEFENSE COSTS WILL BE APPLIED AGAINST THE DEDUCTIBLE. IN NO EVENT WILL WE BE LIABLE FOR DEFENSE COSTS OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT IN EXCESS OF THE LIMIT OF INSURANCE. READ THE ENTIRE POLICY CAREFULLY.

General Information

This section must be completed.

- Expiring Policy Number: EMN 042 98 28
- Name of Applicant: Columbia Community Land Trust
- Physical Street Address: 500 E Walnut, Suite 108
City: Columbia State: MO Zip: 65201
- Mailing Address (☒ same as physical): _____
City: _____ State: _____ Zip: _____
- Website: comolandtrust.com Phone Number: () (573) 874-6321
- Year Established: 2016
- Nature of Business: Managment of Real Estate for Charitable Purpose
- What is the number of locations occupied by the Applicant and subsidiaries? _____
- Does the Applicant have any subsidiaries of which their ownership or management control is greater than 50%? *If yes, please complete table below:* ☐ Yes ☐ No

Name of Subsidiary	Description of Operations	Year Established	Non-Profit (NP) or For-Profit (FP)	Percent Owned
				%
				%
				%
				%

- If annual revenues are less than \$500,000, fully complete the table below or attach most recent annual financials:

	Most Recent Fiscal Year Ending <u>12/31 /2020</u>	Previous Fiscal Year Ending <u>12/31 /2021</u>
Total Assets	\$ 432,182.79	\$ 606,959.29
Total Liabilities	\$ 69.31	\$ 103,917.81
Net Assets or Equity	\$ 432,113.48	\$ 503,041.48
Total Annual Revenues	\$ 581,584.00	\$ 1,104,201.82
Net Income or (Net Loss)	\$ 190,532.24	\$ 70,928.00

11. Please provide the following information regarding the employee count (*do not include Independent Contractors*) of the Applicant and subsidiaries:

	Currently	One Year Ago
Full-Time Employees		
Part-Time Employees		
Temporary/Seasonal		
Volunteers		

Coverages Requested

This section must be completed.

Coverage Part	Per Expiring	Desired Limits if different from expiring
Directors and Officers Liability	<input checked="" type="checkbox"/>	\$
Employment Practices Liability	<input type="checkbox"/>	\$
Fiduciary Liability	<input type="checkbox"/>	\$
Cyber	<input type="checkbox"/>	Complete Cyber Section on Page 3.
Crime	<input type="checkbox"/>	Complete Crime Section on Page 4.

Desired Pay Plan:

Installment Options	Agency Bill	Direct Bill
Annual	<input type="checkbox"/>	<input type="checkbox"/>
Semi-Annual	<input type="checkbox"/>	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	N/A	<input type="checkbox"/>

Directors & Officers Liability Coverage

This section should only be completed if coverage is desired.

- Since the inception of the expiring policy, has the Applicant or any subsidiary:
If yes, please provide details.
 - Had a significant change in operations? ☐ Yes ☒ No
 - Been involved in any actual or proposed merger, acquisition, divestment, consolidation, closing or purchase/sale of assets? ☒ Yes ☐ No
 - Breached any debt covenant, loan agreement or contractual obligations? ☐ Yes ☒ No
- Is Employed Lawyers Professional Liability Coverage desired? ☐ Yes ☒ No
If yes, please complete supplemental questionnaire ML 023 or ML 023 A.

Employment Practices Liability Coverage

This section should only be completed if coverage is desired.

- List the Applicant's total number of employees in the following locations:
CA: _____ WV: _____ Foreign Countries: _____

- Please indicate the number of employee terminations in the table below:

	Last 12 Months	Previous 12 Months
Voluntary		
Involuntary (excluding layoffs)		
Layoffs		

- Do you anticipate any layoffs in the future? *If yes, please provide complete details.* ☐ Yes ☐ No
- Since the inception of the expiring policy, has the Applicant or any subsidiary revised any existing or implemented any new employment policies or procedures? *If yes, please provide details.* ☐ Yes ☐ No

5. Is Third Party Liability Coverage desired? *If yes, complete 5.a.-5.d.* ☐ Yes ☐ No
- a. Are there written policies and procedures regarding the conduct of employees when interacting with third parties (customers, vendors, visitors, independent contractors and other third parties)? ☐ Yes ☐ No
- b. What percentage of employees deal with the general public? _____ %
- c. Does the Applicant have Independent Contractors that are used on a regular basis? ☐ Yes ☐ No
If yes, how many? _____
- d. Is the Applicant's website compliant with the Web Content Accessibility Guidelines (WCAG)? ☐ Yes ☐ No
If no, please advise time frame in which the website will be compliant. _____

Fiduciary Liability Coverage

This section should only be completed if coverage is desired.

1. Complete the table below for any employee benefit plan(s) sponsored by the Applicant and its subsidiaries:

Plan Name	Year Established	Total Plan Assets	Plan Type* (DC, DB or ESOP)	Number of Participants
		\$		
		\$		
		\$		
		\$		

*Plan Type: DC-Defined Contribution, DB-Defined Benefit, ESOP-Employee Stock Ownership Plan

2. Since the inception of the expiring policy, has the Applicant or any subsidiary:
If yes, please provide details.
- a. Had any plan(s) frozen, transferred or terminated? ☐ Yes ☐ No
- b. Made other material changes to the plan(s) listed in the table above? ☐ Yes ☐ No
3. What is the funding percentage for the Applicant's defined benefit retirement plan(s)? ☐ N/A _____ %

Cyber Coverage

This section should only be completed if coverage is desired.

Indicate below if either of the following Cyber options is desired. *Please note that both options cannot be selected.*

- ☐ Option 1 - **Cincinnati Data Defender™** and/or **Cincinnati Network Defender™** - Please check desired coverages, if any. *If higher limits are desired, please complete supplemental questionnaire ML 002.*

Cincinnati Data Defender™	<input type="checkbox"/>
Response Expenses Limit	\$50,000
Defense and Liability Limit	\$50,000
Identity Recovery Limit	\$25,000

Cincinnati Network Defender™	<input type="checkbox"/>
Computer Attack Limit	\$100,000
Network Security Liability Limit	\$100,000

- ☐ Option 2 - **Cincinnati Cyber Defense™** - Application ML 004 must be completed if this coverage is desired.

Crime Coverage

This section should only be completed if coverage is desired.

1. Requested Insuring Agreements <input type="checkbox"/> <i>Per Expiring</i>	Limit of Insurance	Deductible Amount
Employee Theft <input type="checkbox"/> <i>Include ERISA</i> <input type="checkbox"/> <i>ERISA Only</i>	\$	\$
Forgery or Alteration <input type="checkbox"/> <i>Include Credit/Debit Card Forgery</i>	\$	\$
Inside the Premises	\$	\$
Outside the Premises	\$	\$
Computer Fraud	\$	\$
Funds Transfer Fraud	\$	\$
Money Orders and Counterfeit Money	\$	\$
Clients' Property	\$	\$
Claim Expense	\$	\$
Social Engineering Fraud Endorsement	\$	\$

2. Name of employee benefit plan(s) to be included for coverage, if any: _____

3. Please complete the table below with regard to classification of employees of the Applicant and subsidiaries:

Employee Classifications	Total Number
Officers and employees who handle, have custody of or maintain records of money, securities or other property (including that of ERISA plans).	
All other employees not included above.	

4. If Credit/Debit Card Forgery is desired, what is the number of cardholders? _____

5. Since the inception of the expiring policy, has the Applicant or any subsidiary revised any existing or implemented any new policies or procedures that would affect Crime Coverage? ☐ Yes ☐ No
If yes, please provide details.

Crime Expanded Coverage

This section should only be completed if coverage is desired.

1. Please check one of the following in the table below if either Crime Expanded Coverage (XC[®]) or Crime Expanded Coverage Plus (XC+[®]) is desired. The limits and coverages in Crime XC and Crime XC+ are excess of any other crime forms forming part of the same policy, if any.

Insuring Agreements	<input type="checkbox"/> Crime XC	<input type="checkbox"/> Crime XC+
Employee Theft	\$10,000	\$25,000
Forgery or Alteration	\$2,500	\$25,000
Inside the Premises	\$10,000	\$25,000
Outside the Premises	\$2,500	\$5,000
Money Orders and Counterfeit Money	\$10,000	\$25,000

Required Attachments

- Most Recent Annual Financials or IRS 990 Tax Form if **General Information**, question **10.** is not completed
- Current List of Directors & Officers (*if requesting Directors & Officers Liability*)
- Employee Handbook only if updated since last submitted (*if requesting Employment Practices Liability*)
- Blank Employment Application only if updated since last submitted (*if requesting Employment Practices Liability*)
- Most Recent tax form 5500 for each employee benefit plan (*if requesting Fiduciary Liability*)

Signature Section

This section must be completed.

The Cincinnati Insurance Company is hereby authorized to make any investigation and inquiry in connection with this application as it deems necessary.

The undersigned authorizes the release of claim information from any prior insurer to The Cincinnati Insurance Company. Signing this application does not bind the Applicant or The Cincinnati Insurance Company to complete the insurance.

PLEASE REVIEW CAREFULLY. Except to such extent as may be otherwise in the policy, the policy for which this application is being made is limited for ONLY CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED WHILE THE POLICY IS IN FORCE.

Applicant's Signature (President, Chairperson, or Equivalent Position)

Date

Printed Name

Title

Agent's Signature

Date

Agency Name

Agency Code Number

Agent's Name and License Number (Florida only)

Refer to the following page for the current version of ACORD 63 FRAUD STATEMENTS.



AGENCY CUSTOMER ID: _____

FRAUD STATEMENTS

AGENCY		CARRIER	NAIC CODE
POLICY NUMBER	EFFECTIVE DATE	APPLICANT / NAMED INSURED	

Applicable in AL, AR, DC, LA, MD, NM, RI and WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO

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 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.

Applicable in FL and OK

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)*. *Applies in FL Only.

Applicable in KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA

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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

APPLICANT'S SIGNATURE_____
DATE (MM/DD/YYYY)