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CAPITOL INDEMNITY CORPORATION
PLATTE RIVER INSURANCE COMPANY
APPLICATION FOR FIDELITY/FORGERY COVERAGES
COMPREHENSIVE UNDERWRITING & RATING SURVEY

NAMED INSURED: _____
IF ERISA Coverage is needed provide the plan name _____

INSURED'S ADDRESS: _____
Street City County State Zip Code

Are you a Proprietorship Partnership Corporation

1. Type of Business: _____
2. Date Established _____
3. What is the total number of Employees? _____ Total number of Officers? _____
How many employees regularly handle money, securities, or inventory? _____
How many locations? _____ List other locations on reverse side and advise operation.
4. Amount of EMPLOYEE DISHONESTY COVERAGE Desired? \$ _____ Deductible \$ _____
5. Amount of FORGERY COVERAGE Desired? \$ _____ Deductible \$ _____
6. Effective date of coverage requested, if this application is approved? _____
7. Coverage is Primary Coverage is excess over company/policy # _____

INTERNAL CONTROLS:

8. Is an audit performed each year? YES NO
Prepared by: CPA INHOUSE If CPA prepared, Is it an Audit Review Compilation
9. Are bank accounts reconciled by someone not authorized to deposit or withdraw therefrom? YES NO
If no, name and title _____
10. How Often? _____
11. Will all checks issued by the Insured be countersigned? YES NO
If no, who signs (advise name and position) _____

PRESENT COVERAGE:

12. List all fidelity, and forgery coverages now carried: Check if none

Coverage	Limit of Liability	Name of Insurer	Policy Number

LOSS EXPERIENCE:

13. List all employee dishonesty losses in the last three (3) years, itemizing each loss separately: Check if none

Date of Loss	Amount	Description	Precautions Taken to Prevent Repetition

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

The insured represents that the information furnished in this application and any supplemental application is complete, true and correct. Any misrepresentation, omission, concealment or incorrect statement of a material fact, in this application or otherwise, shall be grounds for the rescission of any coverage issued on reliance upon such information. Beware that the underwriting carrier has relied on your answers in accepting, rating and issuing your policy and where applicable in certain jurisdictions, this application becomes part of the policy issued to the Principals as an endorsement

Signed at _____ Insured: _____
This _____ Day of _____, 20____. By: _____
(Signature) Officer or Director (Title)

FRAUD STATEMENT

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 AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

PREMIUM IS FULLY EARNED

**Fax Completed Application To 407-330-3949 _____