

Agency Code:

Name:

Address:

Policy No. _____

**MULTI-EMPLOYER PENSION AND BENEFIT PLAN
FIDUCIARY LIABILITY POLICY**

TWIN CITY FIRE INSURANCE COMPANY
Indianapolis, Indiana

NOTICE: THIS IS A CLAIMS-MADE AND REPORTED POLICY. EXCEPT AS MAY OTHERWISE BE PROVIDED HEREIN, THE COVERAGE OF THIS POLICY IS LIMITED TO LIABILITY FOR WRONGFUL ACTS FOR WHICH CLAIMS ARE FIRST MADE WHILE THE POLICY IS IN FORCE AND WHICH ARE REPORTED TO THE INSURER NO LATER THAN SIXTY (60) DAYS AFTER THE TERMINATION OF THE POLICY. PLEASE READ AND REVIEW THE POLICY CAREFULLY.

THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSS, INCLUDING JUDGMENT OR SETTLEMENT AMOUNTS, SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE AND OTHER CLAIMS EXPENSES.

THE INSURER HAS THE RIGHT AND DUTY TO DEFEND ANY CLAIM COVERED BY THIS POLICY.

DECLARATIONS
SPECIMEN

ITEM A 1. NAME AND ADDRESS OF INSURED PLAN OR TRUST:

2. NAME AND ADDRESS OF INSURED REPRESENTATIVE:

ITEM B POLICY PERIOD: From 12:01 a.m. standard time at the address stated in Item A on _____ (Inception Date) to 12:01 a.m. on _____ (Expiration Date).

ITEM C LIMIT OF LIABILITY:
\$ _____ in the aggregate each Policy Period, including Claims Expenses

ITEM D RETENTION: \$ _____ applicable to Claims Expenses only

ITEM E DISCOVERY PERIOD PREMIUM: _____ % of Total Annual Premium
DISCOVERY PERIOD : (_____) months

ITEM F CONTINUITY DATE: _____

ITEM G TOTAL ANNUAL PREMIUM: \$ _____

ITEM H Form numbers of endorsements attached at issuance:

This Declarations Page, together with the completed and signed Application, including all attachments and exhibits, and the attached Multi-Employer Pension and Benefit Plan Fiduciary Liability Policy form, and all endorsements thereto, shall constitute the contract between the Insureds and the Insurer.

Date: _____ Authorized Representative _____