Subsidiary Supplemental Application

(THIS BECOMES A PART OF THE APPLICATION AND WILL BE ATTACHED TO THE POLICY IF COVERAGE IS ORDERED)

Parent: ____________________

Subsidiary's Name: ____________________

Subsidiary's Address: ____________________

City: ____________________ State: ________ Zip Code: ________

1. Date the subsidiary was created ____/____/____.
2. Is the subsidiary separately incorporated? ☐ Yes ☐ No
3. Is the subsidiary a non-profit? ☐ Yes ☐ No
4. Is the subsidiary wholly owned by the insured? ☐ Yes ☐ No
5. Was the subsidiary created solely for the insured's benefit? ☐ Yes ☐ No
   (If no, please advise other parties involved)
6. Does the subsidiary operate under the insured's bylaws? ☐ Yes ☐ No
   (If no, please forward a copy)
7. Are the subsidiary's finances included in the insured's financial statement (CPA audit, 990 tax form)? ☐ Yes ☐ No
   (If no, please forward a copy of the subsidiary's annual financial documentation.)
   a) Please state the subsidiary's annual revenue: $____________________
   b) Please state the subsidiary's total assets: $____________________
8. Do the insured and its subsidiary share employees and volunteers? ☐ Yes ☐ No
9. Do the insured and its subsidiary operate under the same board of director? ☐ Yes ☐ No
10. Making use of the following space please describe the subsidiary's purpose: ____________________

Claims History:
Within the last three years, has the applicant, its directors, officers and/or any other proposed insured person received any complaint, suit, inquiry or notice of a hearing from any state or federal legislative committee, regulatory body, or any other party? *(If yes, please provide a detail summary.)* ☐ Yes ☐ No

Prior Knowledge:
Is any potential INSURED aware of any circumstance(s) or action(s) which could result in a future claim against any potential INSURED? *(If yes, please provide a detail summary.)* ☐ Yes ☐ No
It is understood and agreed that there will be no coverage for any claim which is related to or arises out of the matter which is set forth, or should have been set forth in this section.

False Information:
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 is committing a fraudulent insurance act, which is a crime and subjects such person to criminal civil penalties.

Signed **X** ____________________ Date ____/____/____

Print Name: ____________________ Title: ____________________
To be signed by the Executive Director, Chairman of the Board or President.

Act Promptly! FAX Application
1-202-857-0143

Questions? Call Toll-Free
1-800-432-7465

Aon Association Services, 1120 20th Street, NW Washington, D.C. 20036-3406
Aon Association Services, a Division of Affinity Insurance Services, Inc., in CA, MN & OK a Division of AIS Affinity Insurance Agency, Inc., and in NH & NY a Division of AIS Affinity Insurance Agency.

Underwritten by The Hartford's Twin City Fire Insurance Company in Arizona, California, Florida, Hawaii, Louisiana and New Hampshire and by the Trumbull Insurance Company in all other states.

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