THE HARTFORD PREMIER DEFENSE FIDUCIARY LIABILITY POLICY℠

DECLARATIONS

_____,
A stock insurance company, herein called the Insurer

Policy Number: _____

NOTICE: THIS POLICY PROVIDES CLAIMS MADE AND REPORTED COVERAGE. EXCEPT AS OTHERWISE SPECIFIED HEREIN, COVERAGE APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE. NOTICE OF A CLAIM MUST BE TIMELY REPORTED TO THE INSURER IN ACCORDANCE WITH THE APPLICABLE NOTICE PROVISIONS OF THIS POLICY. PAYMENT OF LOSS (INCLUDING, BUT NOT LIMITED TO, DEFENSE COSTS) REDUCES AND MAY COMPLETELY EXHAUST THE AVAILABLE LIMIT OF LIABILITY AND IS APPLIED AGAINST THE RETENTION. COVERAGE IS SUBJECT TO THE INSURED'S PAYMENT OF THE APPLICABLE RETENTION EXCEPT AS OTHERWISE SPECIFIED IN THE POLICY. PLEASE READ THE POLICY CAREFULLY AND DISCUSS IT WITH YOUR AGENT OR BROKER. THE POLICY DOES NOT PROVIDE FOR ANY DUTY OR OBLIGATION ON THE PART OF THE INSURER TO DEFEND ANY INSURED.

Item 1. Name of Entity and Address:	**Item 2. Producer Code, Name and Address**:

Item 3. Policy Period: From ***(insert time)***. on _____ ("**Inception Date**") To ***(insert time)*** on _____ ("**Expiration Date**")
(local time at the address shown in **Item 1.**)

Item 4. Premium: **$**_____

Item 5. Limit of Liability: **$**_____ in the aggregate each **Policy Period** for all **Loss** under all Insuring Agreements and any extensions thereto combined

Item 6. Sublimits of Liability:

(1) HIPAA Sublimit of Liability	**$**_____	in the aggregate each **Policy Period** for all **HIPAA Privacy Penalties** covered under this Policy.
(2) ACA Sublimit of Liability	**$**_____	in the aggregate each **Policy Period** for all **ACA Penalties** covered under this Policy.
(3) PPA Sublimit of Liability	**$**_____	in the aggregate each **Policy Period** for all **PPA Penalties** covered under this Policy.
(4) 502(c) Sublimit of Liability	**$**_____	in the aggregate each **Policy Period** for all **502(c) Penalties** covered under this Policy.
(5) IRS Tax Penalty Sublimit of Liability	**$**_____	in the aggregate each **Policy Period** for all **IRS Tax Penalties** covered under this Policy.
(6) Settlement Fee Sublimit of Liability	**$**_____	in the aggregate each **Policy Period** for all **Settlement Fees** and **Defense Costs** covered under Insuring Agreement (C).

Item 7. Retention:

INSURING AGREEMENT (A) & EXTENSIONS Fiduciary Liability Coverage, Labor Management Relations Act Coverage & False Allegation Protection	$	each **Claim**
INSURING AGREEMENT (B) Managed Care Liability Coverage	$	each **Claim**
INSURING AGREEMENT (C) Voluntary Settlement Program Coverage	$	each **Settlement Program**, applicable to **Defense Costs** only.
With respect to any other coverage provided under this Policy, unless otherwise specified by endorsement hereto, the **Retention** amount will be the amount specified above for Insuring Agreement (A) for each **Claim**.		

Item 8. Extended Reporting Period:

(A) ERP Premium: ____**%** **(B) ERP Duration**: _____

ERP Premium is the indicated percentage of the **Premium** in ITEM 4, above, plus the annualized amounts of any additional premiums charged during the **Policy Period**.

Item 9. Continuity Dates

Insuring Agreement (A) Continuity Date _____
Insuring Agreement (B) Continuity Date _____
Insuring Agreement (C) Continuity Date _____

With respect to any other coverage provided under this Policy, unless otherwise specified by endorsement hereto, the **Continuity Date** will be the date specified above for Insuring Agreement (A).

Item 10. Address for Notices to the Insurer:

(A) For Claims and Potential Claims:

via mail: The Hartford – Financial Products Claim Department
<insert address>
<insert address>
via email: HFPClaims@thehartford.com
via fax: (917) 464-4000

(B) For notices other than for Claims and Potential Claims:

via mail: The Hartford
<insert address>
<insert address>
via email: HFPExpress@thehartford.com
via fax: 866-586-4550

ITEM 12: Form Numbers of Endorsements Attached at Issuance:

THESE DECLARATIONS, TOGETHER WITH THE COMPLETED AND SIGNED APPLICATION FOR THIS POLICY, THE POLICY FORM AND ANY ENDORSEMENTS ATTACHED HERETO, CONSTITUTE THE ABOVE-NUMBERED INSURANCE POLICY.

Date: _____ Authorized Representative: _____

This Policy shall not be valid unless countersigned by the Insurer's duly authorized representative.