



BURNETT & ASSOCIATES, LLC  
7301 OHMS LN STE 300  
EDINA, MN 55439-2350

**AmFam.com**

I-800-MY AMFAM® (692-6326)

March 13, 2019

116-074

BASS LAKE ASSOCIATION OF WRIGHT COUNTY INC  
C/O JAMES DVORAK  
620 SYCAMORE LN N  
PLYMOUTH, MN 55441-5620





# **NON-PROFIT DIRECTORS & OFFICERS LIABILITY POLICY**

**AMERICAN FAMILY MUTUAL INSURANCE COMPANY, S.I.**

6000 American Pkwy  
Madison WI 53783-0001  
(608) 249-2111

Member of American Family Insurance Group



## NON-PROFIT DIRECTORS & OFFICERS LIABILITY POLICY

### THIS POLICY CONSISTS OF:

DECLARATIONS  
POLICY  
FORMS AND ENDORSEMENTS APPLYING TO THIS POLICY

### QUICK REFERENCE

#### DECLARATIONS

- Named Organization
- Policy Period
- Form Of Business
- Business Description
- Limit Of Liability
- Retention Amounts
- Retroactive Date
- Pending Or Prior Litigation Date
- Extended Reporting Period
- Forms And Endorsements Applying To This Policy
- Total Premium

| POLICY BOOKLET   | BEGINNING ON<br>PAGE |
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| <b>Section I - Insuring Agreements</b> .....               | 1                    |
| <b>Section II - Extensions</b> .....                       | 1                    |
| <b>Section III - Exclusions</b> .....                      | 1                    |
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| <b>Section V - Defense And Settlement</b> .....            | 3                    |
| <b>Section VI - Conditions</b> .....                       | 3                    |
| A. Notice To Us  |                      |
| B. Extended Reporting Period                               |                      |
| C. Assistance And Cooperation                              |                      |
| D. Subrogation   |                      |
| E. Other Insurance   |                      |
| F. Assignment  |                      |
| G. Action Against Us                                       |                      |
| H. Representation And Severability                         |                      |
| I. Changes In Exposure                                     |                      |
| J. Territory And Valuation                                 |                      |
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#### ENDORSEMENTS

#### SPECIAL PROVISIONS FOR AMERICAN FAMILY MUTUAL INSURANCE COMPANY, S.I.

POLICYHOLDERS ..... iii

**IMPORTANT:** This Quick Reference is not part of the Non-Profit Directors & Officers Liability Policy and does not provide coverage. Refer to the Non-Profit Directors & Officers Liability Policy itself for actual contractual provisions.

PLEASE READ THE POLICY CAREFULLY.



**AMERICAN FAMILY MUTUAL INSURANCE COMPANY, S.I.**  
**MADISON, WISCONSIN 53783-0001**  
**NON-PROFIT DIRECTORS AND OFFICERS LIABILITY POLICY**  
**DECLARATIONS**

**POLICY NUMBER**  
22XJ955002

**CUSTOMER BILLING ACCOUNT**  
021-575-212 76

**NOTICE** THIS IS A CLAIMS-MADE POLICY. THIS POLICY CONSISTS OF THIS DECLARATIONS, THE NON-PROFIT DIRECTORS AND OFFICERS LIABILITY POLICY FORM, APPLICABLE ENDORSEMENTS AND THE SIGNED APPLICATION. PLEASE READ THE ENTIRE POLICY CAREFULLY.

**NAMED ORGANIZATION** BASS LAKE ASSOCIATION OF WRIGHT COUNTY INC

**MAILING ADDRESS** C/O JAMES DVORAK  
620 SYCAMORE LN N  
PLYMOUTH, MN 55441-5620

**POLICY PERIOD** FROM 06-01-2019 TO 06-01-2020  
12:01 A.M. Standard Time at your mailing address shown above.

**FORM OF BUSINESS** CORPORATION  
**BUSINESS DESCRIPTION** Homeowners Association

**LIMIT OF LIABILITY**  
Aggregate for Coverage **A, B** and **C, including "claims expenses"** \$1,000,000

**RETENTION AMOUNTS**  
Coverage **A** (each claim) \$500  
Coverage **B** (each claim) \$500  
Coverage **C** (each claim) \$500

**RETROACTIVE DATE**

THIS INSURANCE DOES NOT APPLY TO A "CLAIM" ARISING OUT OF A "WRONGFUL ACT" WHICH OCCURS BEFORE THE RETROACTIVE DATE, IF ANY, SHOWN BELOW.

RETROACTIVE DATE (Coverages **A** and **B**): 06-01-2018  
RETROACTIVE DATE (Coverages **C**): 06-01-2018

**PENDING OR PRIOR LITIGATION DATE**

PENDING OR PRIOR DATE (Coverages **A** and **B**): 06-01-2018  
PENDING OR PRIOR DATE (Coverages **C**): 06-01-2018

**EXTENDED REPORTING PERIOD**

ADDITIONAL PERIOD (Number of Months) None unless added by endorsement to the policy.

**TOTAL DIRECTORS AND OFFICERS PREMIUM** \$64.00  
**TOTAL ADVANCE PREMIUM** \$125.00 MINIMUM

Forms and endorsements applying to and made part of this policy at time of issue:

|                |                |                |                |
|----------------|----------------|----------------|----------------|
| IL 09 85 01 15 | NP 00 00 08 18 | NP 00 01 12 05 | NP 00 03 10 06 |
| NP 01 11 05 09 | NP 02 45 10 06 | NP 21 10 04 03 | NP 21 12 04 03 |
| NP 21 15 01 15 | NP 28 02 04 03 | NP 71 02 12 05 | NP 71 03 12 05 |
| NP 71 04 12 05 | NP 71 07 12 05 |                |                |

**AGENT** 116-074  
BURNETT & ASSOCIATES, LLC  
7301 OHMS LN STE 300  
EDINA, MN 55439-2350

**PHONE**  
1-952-933-8495

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**BRANCH** PLM024 RENW  
**ENTRY DATE** 03-13-2019



AMERICAN FAMILY MUTUAL INSURANCE COMPANY, S.I.  
MADISON, WISCONSIN 53783-0001

NON-PROFIT DIRECTORS AND OFFICERS LIABILITY POLICY

DECLARATIONS

POLICY NUMBER

22XJ955002

CUSTOMER BILLING ACCOUNT

021-575-212 76

AUTHORIZED  
REPRESENTATIVE

*William B. Westra*  
President

*[Signature]*  
Secretary

COUNTERSIGNED  
LICENSED RESIDENT AGENT

AGENT 116-074  
BURNETT & ASSOCIATES, LLC  
7301 OHMS LN STE 300  
EDINA, MN 55439-2350

PHONE  
1-952-933-8495

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BRANCH PLM024 RENW  
ENTRY DATE 03-13-2019



# NON-PROFIT DIRECTORS AND OFFICERS LIABILITY APPLICATION (Claims Made)

AGENT

Burnett & Associates LLC  
7301 Ohms Lane Suite 300  
Edina, MN 55439

|                                      |             |
|--------------------------------------|-------------|
| AGT<br>116                           | DIST<br>074 |
| PHONE<br>(952) 933-8495              |             |
| FAX                                  |             |
| E-MAIL ADDRESS<br>kburnett@amfam.com |             |

American Family Mutual Insurance Company, S.I.  
American Family Insurance Company  
Members of American Family Insurance Group  
Madison, Wisconsin 53783-0001

**Attach to Commercial Applicant Information Application UBL-10 00.** (Commercial Applicant Information Application is not required for the same Named Organization in the last 12 months unless requested by your underwriter.)

|  |                                      |               |              |                          |
|--|--------------------------------------|---------------|--------------|--------------------------|
| TRANSACTION TYPE<br><b>Bound/Issue</b> | NEED BY DATE                         | POLICY NUMBER | QUOTE NUMBER | EFFECTIVE DATE OF CHANGE |
| WHO REQUESTED CHANGE                   | DESCRIBE (if other requested change) |               |              |                          |

**APPLICANT INFORMATION**

NAMED ORGANIZATION  
**Bass Lake Association of Wright County, Inc**

**POLICY MAILING ADDRESS**

MAILING ADDRESS Check if Foreign   
STREET, P.O. BOX, RR BOX  
**620 Sycamore Ln N**  
CITY  
**Plymouth** STATE **MN** ZIP+4 **55441** COUNTRY **US**

**POLICY EFFECTIVE/EXPIRATION DATE**

EFFECTIVE DATE (Mo., Day, Yr.)  
**06/01/2018** EXPIRATION DATE (Mo., Day, Yr.)  
**06/01/2019**

**PRIOR CARRIER INFORMATION**

|                 |              |                     |   |                  |
|-----------------|--------------|---------------------|---|------------------|
| EXPIRATION DATE | CARRIER NAME | PRIOR PREMIUM<br>\$ | CLAIMS MADE<br><input type="checkbox"/> Yes <input type="checkbox"/> No | RETROACTIVE DATE |
|-----------------|--------------|---------------------|---|------------------|

**LOCATION/RATING INFORMATION**

BUSINESS DESCRIPTION  
**Homeowners Assoc**

|  |   |                                  |                                 |
|--|---|----------------------------------|---------------------------------|
| RETROACTIVE DATE (Claims Made Policy)<br><b>06/01/2018</b> | PENDING OR PRIOR LITIGATION DATE<br>Date is the same as the policy effective date | TOTAL ASSETS<br><b>\$ 15,000</b> | NUMBER OF EMPLOYEES<br><b>0</b> |
|--|---|----------------------------------|---------------------------------|

**COVERAGE/LIMITS**

|   |   |   |
|---|---|---|
| EACH OCCURRENCE & AGGREGATE LIMIT<br><b>\$1,000,000</b> | RETENTION AMOUNT (Deductible)<br><b>\$500</b> | RATING STATE (Organization's State Location)<br><b>MN</b> |
|---|---|---|

**GENERAL INFORMATION**

|  |   |
|--|---|
| 1. Any prior negligent act, error, omission or breach of duty? .....         | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 2. Any pending litigation or claims? .....                                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 3. Other than unit owners have a financial interest in the risk? .....       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 4. Developer serves as a board member? .....                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 5. All financial records audited at least annually? .....                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 6. Entire Board of Directors review all financial audits? .....              | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Supporting BOP or BKP for the Named Organization? .....                   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Any subsidiary organizations controlled by the applicant? .....           | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Were any subsidiary organizations controlled by the applicant sold? ..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

**PREMIUMS**

**\$ 125**

**CLAIMS MADE STATEMENT**

This application is for a Claims-Made policy. Claims must be first made against the insured during the Policy Period and reported to us in writing as soon as practicable but in no event later than sixty (60) days after the end of the Policy Period. The insurance for this application applies only if the Wrongful Act out of which the Claim arose occurred on or after the Retroactive Date, if any, shown in the declarations, and before the end of the Policy Period. Claims Expenses are payable within, not in addition to, the Each Occurrence & Aggregate Limit selected.



**EXPLANATION OF QUESTIONS**

Question 7: Pending

**REMARKS**

Quote #Q22J955001

**BILLING INSTRUCTIONS**

SEND BILL TO

First Named Insured  Other Party

OTHER PARTY NAME

BILLING ADDRESS  Check If Foreign

STREET, P.O. BOX, RR BOX  
620 Sycamore Ln N

CITY  
Plymouth

STATE  
MN

ZIP+4  
55441

COUNTRY  
US

BILLING PLAN

Customer Billing

ACCOUNT TYPE

ACCOUNT NUMBER

AUTOMATED FUNDS TRANSFER (AFT)

Yes  No

DOWN PAYMENT METHOD

DOWN PAYMENT AMOUNT

\$

**APPLICANT AND AGENT CERTIFICATION (To be completed only if not submitted with Commercial Applicant Information Application UBL-10 00)**

**All Applicants:**

1. I understand that the coverage and limits I selected on this Application and in any state supplements will apply to all future policy renewals and changes unless I notify you in writing.
2. All statements made in this Application are accurate to the best of my knowledge and the Company can rely upon my statements in issuing a policy.
3. I understand that any rate quoted by the agent is an estimate and subject to final determination by the Company. The agent has no authority to bind rates.
4. Any individual who with intent to defraud an insurance company or other person, files an application or statement of claim with false material information, or conceals information material to the application or claim, commits insurance fraud, a crime subject to [NY: Substantial] civil and criminal penalty. [Not applicable in CO, HI, NE, OH, OK, OR, VT and UT (WC only) in DC, LA, ME and VA insurance benefits may also be denied].

**All Agents:**

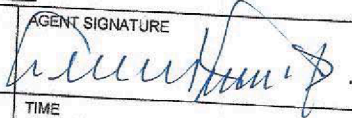
1. It is your responsibility to complete & forward all required forms based on current State Statutes.
2. I have personally viewed the risk associated with this application and it meets our eligibility requirements.
3. Application Point Month of Credit

APPLICANT SIGNATURE

DocuSigned by:

James Anthony Dvorak, III

AGENT SIGNATURE



DATE APPLICATION TAKEN

06/01/2018

TIME  
01:00

A.M.  P.M.



## Special Provisions for American Family Mutual Insurance Company, S.I. Policyholders

### 1. MEMBERSHIP AND VOTING

While this policy is in force, each insured named in the Declarations is considered an owner or policyholder and a member of the American Family Insurance Mutual Holding Company (AFIMHC) of Madison, Wisconsin. As a member, you are entitled to one vote at all meetings either in person or by proxy. You can only cast one vote regardless of the number of policies or coverage you purchased. If two or more persons qualify as a member under a single policy, they are considered one member for purposes of voting. The owner of a group policy will have one vote regardless of the number of persons insured or coverage purchased. Fractional voting is not allowed. If you are a minor, any vote will be given to your parent or legal guardian.


### 2. ANNUAL MEETINGS

The Annual Meetings are held at the Home Office: 6000 American Parkway, Madison, Wisconsin, on the first Tuesday of March at 2:00 P.M. Central Standard Time. Notice in this policy shall be sufficient notification.

### 3. DIVIDENDS

If any dividends are declared, you will share in them according to law and under conditions set by the Board of Directors.

This policy is signed at Madison, Wisconsin, on **our** behalf by **our** President and Secretary. If it is required by law, it is countersigned on the declarations by **our** authorized representative.



President



Secretary

**This is not a complete and valid contract without accompanying DECLARATIONS properly executed**



