

SERFF Tracking Number: CSIC-125710033 State: Arkansas
Filing Company: ProCentury Insurance Company State Tracking Number: #? \$50
Company Tracking Number: 135
TOI: 23.0 Fidelity Sub-TOI: 23.0000 Fidelity
Product Name: Fidelity Filing
Project Name/Number: /

Filing at a Glance

Company: ProCentury Insurance Company

Product Name: Fidelity Filing

TOI: 23.0 Fidelity

Sub-TOI: 23.0000 Fidelity

Filing Type: Form

SERFF Tr Num: CSIC-125710033

SERFF Status: Closed

Co Tr Num: 135

Co Status:

Authors: Ernie Taylor, Maria

Reinmann, Teresa Fenton

Date Submitted: 08/12/2008

State: Arkansas

State Tr Num: #? \$50

State Status: Fees verified

Reviewer(s): Betty Montesi,
Llyweyia Rawlins

Disposition Date: 08/18/2008

Disposition Status: Approved

Effective Date Requested (New): 09/06/2008

Effective Date Requested (Renewal):

Effective Date (New): 09/06/2008

Effective Date (Renewal):

State Filing Description:

General Information

Project Name:

Project Number:

Reference Organization: SFAA

Reference Title:

Filing Status Changed: 08/18/2008

State Status Changed: 08/13/2008

Corresponding Filing Tracking Number:

Filing Description:

This is an adoption filing of the Surety and Fidelity Association of America's (SFAA) forms. We are including our own forms with this filing.

Status of Filing in Domicile: Pending

Domicile Status Comments:

Reference Number:

Advisory Org. Circular:

Deemer Date:

Company and Contact

Filing Contact Information

Maria Reinmann, CPCU, AIS, Regulatory

MReinmann@centurysurety.com

SERFF Tracking Number: CSIC-125710033 State: Arkansas
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Operations Filing Analyst

465 Cleveland Ave (866) 772-7481 [Phone]
Westerville, OH 43082 (614) 823-6349[FAX]

Filing Company Information

ProCentury Insurance Company CoCode: 21903 State of Domicile: Texas
465 Cleveland Ave Group Code: 959 Company Type: Property and
Casualty
Westerville, OH 43082 Group Name: ProCentury Ins State ID Number:
Group
(800) 895-2000 ext. [Phone] FEIN Number: 94-6078027

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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Llyweyia Rawlins	08/18/2008	08/18/2008

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Disposition

Disposition Date: 08/18/2008

Effective Date (New): 09/06/2008

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Commercial Crime App	Approved	Yes
Form	Commercial Crime App	Approved	Yes
Form	Business Service Bond Application	Approved	Yes
Form	Business Service Bond	Approved	Yes
Form	Commercial Crime Declarations	Approved	Yes
Form	Faithful Performance of Duty	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type	Action	Action Specific Data	Readability	Attachment
Approved	Commercial Crime App	CSB 2001	08/07	Application/ New Binder/Enrollment			0.00	CSB20010807.pdf
Approved	Commercial Crime App	CSB 2002	08/07	Application/ New Binder/Enrollment			0.00	CSB20020807.pdf
Approved	Business Service Bond Application	CSB 2003	08/07	Application/ New Binder/Enrollment			0.00	CSB20030807.pdf
Approved	Business Service Bond	CSB 2004	08/07	Bond	New		0.00	CSB20040807.pdf
Approved	Commercial Crime Declarations	CSB 2005	10/07	Declaration	New s/Schedule		0.00	CSB20051007.pdf
Approved	Faithful Performance of Duty	CSB 2008	12/07	Bond	New		0.00	CSB20081207.pdf



ProCentury Insurance Company

APPLICATION FOR A COMMERCIAL CRIME POLICY FOR MERCANTILE ENTITIES

This form must be completed for each new policy and at the beginning of each premium period for renewal policies.

Agent _____ Agency _____

License Number _____ City/State _____

Application is hereby made by _____

Principal Address _____
(No.) (Street) (City) (State) (Zip Code)

for a **Commercial Crime Policy** with:

<u>Coverage Forms</u>	<u>Limit of Insurance</u>
Coverage Form A - Employee Dishonesty - Blanket <input type="checkbox"/>	\$ _____
Coverage Form A - Employee Dishonesty - Schedule <input type="checkbox"/> (see Item 8 on page 4)	
Coverage Form B - Forgery or Alteration	\$ _____

to become effective or to be continued as of 12:01 a. m. on _____ to 12:01 a. m. on _____

Premium payable (check the appropriate box): Annual , Three year prepaid , Three equal annual installments , Other _____

1. DESCRIPTION OF YOUR ORGANIZATION:

- (a) Are you a (check the appropriate box): Proprietorship , Partnership , Corporation
- (b) Date your business was established _____
- (c) Classify your predominant activity (check the appropriate box): Manufacturer , Processor , Wholesaler , Distributor , Retailer , Servicer , Other _____
- (d) Describe the products or services of your predominant business or activity _____
- (e) Has there been any change in ownership or management within the past three years? Yes No
If "yes", explain _____

2. AUDIT PROCEDURES:

- (a) Is there an audit by a CPA, public accountant or equivalent, independent of your organization? Yes No
If "Yes", how often (check the appropriate box): Quarterly , Semi-Annually , Annually
- (b) Name and address of person or firm performing audit _____
- (c) Are all locations audited? Yes No
- (d) Is the audit made in accordance with generally accepted auditing standards and so certified? Yes No
If "No", explain the scope of the audit _____
- (e) Is the audit report rendered directly to the proprietor, partners if a partnership or Board of Directors if a corporation? Yes No
- (f) Date of completion of last audit of: cash and accounts _____ inventory _____
- (g) Were any discrepancies or loose practices commented upon in the audit? Yes No
If "Yes", submit a copy of the audit and auditor's comments _____
- (h) Is there an internal audit by an Internal Audit Department under the control of an employee who is a public accountant or equivalent? Yes No
If "Yes", are the reports rendered directly to the proprietor, partners if a partnership or Board of Directors if a corporation? Yes No

3. INTERNAL CONTROL (OTHER THAN AUDIT PROCEDURES):

- (a) Are bank accounts reconciled by someone not authorized to deposit or withdraw? Yes No
If "No", explain _____

- (b) Is countersignature of checks required? Yes No
 If "No", explain _____
- (c) Are securities subject to joint control of two or more responsible employees? Yes No
 If "No", explain _____

4. PRIOR INSURANCE:

- (a) Has any similar insurance been declined or cancelled during the past three years? Yes No
 If "Yes", explain _____

- (b) Prior insurance to be superseded Check if none

Form of Insurance	Effective Date	Expiration Date	Limit of Insurance	Name of Insurance Company
			\$	

- (c) List below all fidelity and forgery losses sustained during the past three years, whether reimbursed or not from _____ to _____ Check if none
(month, day, year) (month, day, year)

Date of Loss	Type of Loss	Amount of Loss	Amount Recovered from Insurance	Amount Recovered from other than Insurance	Amount of Loss Pending	If Loss occurred at other than Head Office, state location
		\$	\$	\$	\$	

5. RATING DATA FOR COVERAGE FORM A-BLANKET AND B:

- (a) Classification of Employees:

(1) Number of Officers _____

(2) List below the number of employees in the following classifications:

No. of	No. of	No. of
_____ Accountants and Asst. Accountants	_____ Custodians	_____ Refinery Gaugers of Oil Companies
_____ Adjusters	_____ Delivery Persons	_____ handling refined gasoline and oils.
_____ Administrators and Asst. Administrators	_____ Demonstrators	_____ Salespeople
_____ Appraisers and Clerks acting as Appraisers	_____ Detectives	_____ Security Personnel
_____ Attorneys	_____ Dieticians who order food	_____ Service Station Attendants
_____ Auditors and Asst. Auditors	_____ Drivers and Drivers' Helpers	_____ Shipping Clerks
_____ Bookkeepers	_____ Floor Walkers	_____ Stewards/esses who order food
_____ Bursars and Asst. Bursars	_____ Food Inspectors	_____ Stock Clerks
_____ Bus Drivers	_____ Head Pharmacists	_____ Storekeepers
_____ Buyers and Asst. Buyers	_____ Instructors having custody of money or securities	_____ Storeroom Personnel
_____ Canvassers (door-to-door Salespeople)	_____ Janitors	_____ Superintendents and Asst. Superintendents
_____ Cashiers and Asst. Cashiers	_____ Ledger Keepers	_____ Supervisors and Asst. Supervisors
_____ Chairpersons	_____ Locker Room Attendants	_____ Taxi Drivers
_____ Chauffeurs	_____ Maitre d's and Asst. Maitre d's	_____ Teachers having custody of money or securities
_____ Checkers, food and beverage	_____ Managers and Asst. Managers	_____ Timekeepers and Asst. Timekeepers
_____ Chefs who order food	_____ Medical Directors	_____ Truck Drivers
_____ Collectors	_____ Messengers, outside	_____ Warehouse Personnel
_____ Computer Programmers	_____ Meter Readers who collect	_____ Wine Cellar Personnel
_____ Comptrollers and Asst. Comptrollers	_____ Payroll Distributors	_____ Wine Stewards/esses
_____ Credit Clerks and Managers	_____ Professors having custody of money or securities	_____ All other employees not listed above who handle, have custody of maintain records of money, securities or other property
	_____ Purchasing Agents & Asst. Purchasing Agents	
	_____ Receiving Clerks	

(cont'd)

(3) Number of all other employees _____

5. RATING DATA FOR COVERAGE FORMS A - BLANKET AND B:

(b) Number of additional locations other than the head office _____
(For manufacturers, processors, wholesalers or distributors show only additional retail locations.)

(c) Deductibles: Deductible Amount

(1) Coverage Form A - Blanket.

a. All employees \$ _____

b. Specified positions \$ _____

List below the positions and number of employees occupying those positions:

<u>No. of Employees</u>	<u>Position(s)</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(2) Coverage Form B \$ _____

6. COVERAGE AMENDMENTS (ENDORSEMENTS) - COVERAGE FORM A - BLANKET:

(a) If insurance is desired on any of your appointed or elected agents, whether they be persons, partnerships or corporations performing any act or service in connection with the ordinary conduct of your business, complete the following:

<u>Capacity in Which Each Agent Serves</u>	<u>Limit of Insurance</u>
_____	\$ _____
_____	_____
_____	_____
_____	_____

(b) If insurance is desired on any of your partners, list names below:
Name(s)

(c) If Insurance is desired on workers leased to you under a written agreement with a labor leasing firm (other than temporary help hired to substitute for permanent employees on leave, or to meet seasonal or short term workload conditions), complete the following:

<u>Name of Labor Leasing Firm</u>	<u>No. of Leased Workers</u>
_____	_____
_____	_____
_____	_____

(d) If blanket excess limits of insurance are desired on any of your Joint Insureds, complete the following:

<u>Joint Insured (s)</u>	<u>No. of Employees</u>	<u>Excess Limit of Insurance</u>
_____	_____	\$ _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(cont'd)

(e) If excess limits of insurance are desired on any of your employees on either a name schedule or position schedule basis, complete the following:

Item No.	Name Schedule Coverage	Position Schedule Coverage			Excess Limit of Insurance Each Employee
	Name(s) of Covered Employee (s)	Title (s) of Covered Position (s)	Location of Covered Position(s) (City and State)	No. of Employees Each Position	

7. COVERAGE AMENDMENTS (ENDORSEMENTS) COVERAGE FORM B

If insurance is desired, complete the following:

(a) Credit, Debit or Charge Card Instruments:

Covered instruments (check the appropriate box) include or are limited to credit, debit or charge cards issued to you or any employee for business purposes

No. of
Cardholders

Limit of Insurance

_____ \$ _____

(b) Warehouse Receipts:

Covered instruments (check the appropriate box) include or are limited to warehouse receipts and withdrawal orders

\$ _____

(c) Personal Accounts of your officers or partners, list names below:

Name(s)

\$ _____

8. RATING DATA FOR COVERAGE FORM A - SCHEDULE:

If insurance is desired on any of your employees on either a name schedule or position schedule basis, complete the following:

Item No.	Name Schedule Coverage	Position Schedule Coverage			Limit of Insurance Each Employee	Deductible Amount
	Name(s) of Covered Employee(s)	Title(s) of Covered Position(s)	Location of Covered Positions(s)	No. of Employees Each Position		
					\$	\$

9. The present officers, employees, agents and partners of the Insured, have 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 indicated that any of the said officers, employees, agents or partners are dishonest. Such knowledge that any official or officer signing for the Insured may now have in respect to his or her own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

Dated _____

By _____
(Name and Title)

(Insured)



ProCentury Insurance Company

APPLICATION FOR A COMMERCIAL CRIME POLICY FOR GOVERNMENTAL ENTITIES

This form must be completed for each new policy and at the beginning of each premium period for renewal policies.

Agent _____ License Number _____

Agency _____ City _____ State _____ Zip _____

Application is hereby made by _____
(List all Insureds)

Principal Address _____
(No.) (Street) (City) (State) (Zip Code)

for a (check the appropriate box): Discovery , Loss Sustained _____ **Commercial Crime Policy with:**
(primary, excess, contributing)

Coverage Forms

Limit of Insurance

Coverage Form O - Public Employee Dishonesty - Per Loss Coverage

\$ _____

Coverage Form P - Public Employee Dishonesty - Per Employee Coverage

\$ _____

Coverage Form B - Forgery or Alteration

\$ _____

to become effective or to be continued as of 12:01 a.m. on _____ to 12:01 a. m. _____

Premium payable (check the appropriate box): **Prepaid:** Annual , Two year , Three year , Four year
Equal Annual Installments: Two year , Three year , Four year

1. If this insurance indemnifies an Obligee other than the Named Insured, list below the name and address of the Obligee:

2. DESCRIPTION OF YOUR ORGANIZATION:

(a) Is your organization a part of the government of the (check the appropriate box): State , County , City Town Township ,
Village , Borough , Other Political Subdivision

(b) Is Insurance being provided for a School System? Yes No

3. AUDIT PROCEDURES

(a) Is there an audit by a CPA, public accountant or equivalent, independent of your organization? Yes No
If "Yes", how often (check appropriate box): Quarterly , Semi-Annually , Annually

(b) Name and Address of person or firm performing audit _____

(c) Are all locations audited? Yes No

(d) Is the audit made in accordance with generally accepted auditing standards and so certified? Yes No
If "No", explain the scope of the audit _____

(e) Is the audit report rendered to a regulatory authority? Yes No
If "Yes", to whom are the reports rendered? _____

(f) Date of completion of last audit _____

(g) Were any discrepancies or loose practices commented upon in the audit? Yes No
If "Yes", submit a copy of the audit and auditor's comments.

(h) Is there an internal audit by an Internal Audit Department under the control of an employee who is a public accountant or equivalent? Yes No
If "Yes", to whom are the reports rendered? _____

4. INTERNAL CONTROLS (OTHER THAN AUDIT PROCEDURES):

(a) Are bank accounts reconciled by someone not authorized to deposit or withdraw? Yes No
If "No", explain _____

(b) Is countersignature of checks required? Yes No
If "No", explain _____

(c) Are securities subject to joint control of two or more responsible employees? Yes No
If "No", explain _____

6. **RATING DATA FOR COVERAGE FORMS O, P and B (cont'd):**

- (2) From the list on page 2 (or attached separate sheet) determine the:
- a. Number of officials/officers required by law to be individually bonded, who are authorized to manage, govern or control the Insured's employees
 - b. Number of employees who handle, have custody or maintain records of money, securities or other property; department and division heads; assistant department and division heads; and peace officers (including patrolmen when Faithful Performance of Duty Coverage is being written)
 - c. Number of all other employees (including patrolmen, when written for Honesty Coverage only)

(b) Deductibles

(1) Coverage Forms O and P

a. All employees

Amount
\$ _____

b. Specified positions

\$ _____

List below the positions and number of employees occupying those positions:

<u>No. of Employees</u>	<u>Position(s)</u>

(2) Coverage Form B \$ _____

7. **COVERAGE AMENDMENTS (ENDORSEMENTS) - COVERAGE FORMS O and P:**

- (a) Is Faithful Performance of Duty Coverage required? Yes No
- (b) If insurance is desired on any of your appointed or elected agents, whether they be persons, partnerships or corporations while performing any act or service in connection with the ordinary function of your organization, complete the following:

<u>Capacity in Which Each Agent Serves</u>	<u>Limit of Insurance</u>
	\$ _____

- (c) If insurance is desired on workers leased to you under a written agreement with a labor leasing firm (other than temporary help hired to substitute for permanent employees on leave, or to meet seasonal or short-term workload conditions), complete the following:

<u>Name of Labor Leasing Firm</u>	<u>No. of Leased Workers</u>

- (d) If blanket excess limits of insurance are desired on any of your Joint Insureds, complete the following:

<u>Joint Insured(s)</u>	<u>No. of Employees</u>	<u>Excess Limit of Insurance</u>
		\$ _____

7. **COVERAGE AMENDMENTS (ENDORSEMENTS) - COVERAGE FORMS O and P (cont'd):**

(e) If excess limits of insurance are desired on any of your employees on either a name schedule or position schedule basis, complete the following:

Item No.	Name Schedule Coverage	Position Schedule Coverage			Excess Limit of Insurance Each Employee
	Name(s) of Covered Employees	Title(s) of Covered Position(s)	Location of Covered Position(s)	No. of Employees Each Position	

Is Faithful Performance of Duty Coverage required on the employees or positions listed above? Yes No

8. **COVERAGE AMENDMENT (ENDORSEMENT) - COVERAGE FORM B:**

If insurance is desired, complete the following:

Credit, Debit or Charge Card Instruments:

Covered instruments (check the appropriate box) included or are limited to credit, debit or charge cards issued to you or any employee for business purposes

No. of Cardholders _____

Limit of Insurance \$ _____

9. The present officials/officers and employees of the Insured, in the positions held, are shown herein, have 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 indicated that any of the said officials/officers or employees are dishonest. Such knowledge that any official or officer signing for the Insured may now have in respect to his or her own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

Dated at _____ this _____ day of _____, _____

By _____

(Insured)

(Name and Title)



APPLICATION FOR BUSINESS SERVICE BOND

Agency:

Location:

Name of Applicant:

Address:

Effective Date:

Type of Business:

What Amount of Coverage is Desired on this Policy:

\$5,000 \$10,000 \$25,000 \$50,000

Number of Owners:

Number of Employees:

What Company Writes Applicants Liability Insurance:

Liability Coverage Amount: \$

Have there been any dishonesty losses in the past 6 years? Yes No

(If Yes, Submit Details and Corrective Action Taken Under Separate Cover)

BOND COVERAGE APPLIES ONLY IF EMPLOYEE IS CONVICTED

Coverage Provided For But Not Limited To:

Janitorial Services
Pest Control
Maid Service
Home Photographer

Security Guards
Carpet Cleaners
Appliance Repair
Food Catering

Interior Decorator
Locksmiths
Messenger Service
Other Contractors



BUSINESS SERVICE BOND

BOND NO. PSB

In consideration of an agreed premium, ProCentury Insurance Company, 465 North Cleveland Avenue, Westerville, OH 43082, (hereinafter called "Surety"), hereby agrees to indemnify _____

of _____, (hereinafter called "Obligee"), against direct loss of money or other property, from the premises of any and all subscribers (hereinafter called "Subscriber") to its services, and belonging to the Subscriber, or in which the Subscriber has a pecuniary interest or for which the Subscriber is legally liable, which the Subscriber shall sustain as the result of any fraudulent or dishonest act, as hereinafter defined, of an Employee or Employees of the Obligee acting alone or in collusion with others, and for which the Obligee is liable, to an amount not exceeding in the aggregate, _____, for that amount in excess of the per loss deductible of \$250.

THE FOREGOING AGREEMENT IS SUBJECT TO THE FOLLOWING CONDITIONS AND LIMITATIONS:

TERM OF BOND:

Section 1. The term of this bond begins at 12:01 A.M. on _____ at the address of the Obligee above given, and ends at 12:01 A.M. Standard Time on the effective date of the cancellation of this bond in its entirety.

DISCOVERY PERIOD:

Section 2. Loss is covered under this bond only (a) if sustained through any act or acts committed by an Employee of Obligee while this bond is in force to such Employee, and (b) if discovered within no more than 180 days after the expiration or sooner cancellation of this bond in its entirety as provided in Section 10, or from its cancellation or termination in its entirety in any other manner, whichever shall first happen.

DEFINITION OF EMPLOYEE:

Section 3. The word Employee or Employees, as used in this bond, shall be deemed to mean, respectively, one or more of the natural persons (except directors or trustees of the Obligee, if a corporation, who are not also officers or employees thereof in some other capacity) while in the regular service of the Obligee in the ordinary course of the Obligee's business during the term of this bond, and whom the Obligee compensates by salary, or wages and has the right to govern and direct in the performance of such service, and who are engaged in such service within any State of the United States of America, or within the District of Columbia, Puerto Rico, the Virgin Islands, or elsewhere for a limited period, but not to mean brokers, factors, commission merchants, consignees, contractors, or other agents or representatives of the same general character. If the Obligee is a sole proprietorship or partnership, the proprietor or partners shall be considered to be Employees for the purposes of this bond.

FRAUDULENT OR DISHONEST ACT:

Section 4. A fraudulent or dishonest act of any Employee or Obligee shall mean a fraudulent or dishonest act causing loss during the time the Employee is engaged in services on the premises of the Subscriber, and which is punishable under the Criminal Code in the jurisdiction within which act occurred, for which said Employee is tried and convicted by a court of proper jurisdiction.

MERGER OR CONSOLIDATION:

Section 5. If any natural persons shall be taken into the regular service of the Obligee through merger or consolidation with some other concern, the Obligee shall give the Surety written notice thereof and shall pay an additional premium on any increase in the number of Employees covered under this bond as a result of such merger or consolidation computed pro rata from the date of such merger or consolidation to the end of the current premium period.

NON-ACCUMULATION OF LIABILITY:

Section 6. Regardless of the number of years this bond shall continue in force and the number of premiums which shall be payable or paid, the liability of the Surety under this bond shall not be cumulative in amounts from year to year or from period to period.

LIMIT OF LIABILITY UNDER THIS BOND AND PRIOR INSURANCE:

Section 7. With respect to loss or losses caused by an Employee or which are chargeable to such Employee as provided in Section 4 and which occur partly under this bond and partly under other bonds or policies issued by the Surety to the Obligee or to any predecessor in interest of the Obligee and terminated or cancelled or allowed to expire and in which the period for discovery has not expired at the time any such loss or losses thereunder are discovered, the total liability of the Surety under this bond and under such other bonds or policies shall not exceed, in the aggregate, the amount carried under this bond and such loss or losses or the amount available to the Obligee under such other bonds or policies, as limited by the terms and conditions thereof, for any such loss or losses, if the latter amount be the larger.

Section 8. If the Obligee shall sustain any loss or losses covered by this bond which exceed the amount of coverage provided by this bond, the Obligee shall be entitled to all recoveries, except from suretyship, insurance, reinsurance security and indemnity taken by or for the benefit of the Surety, by whomsoever made, on account of such loss or losses under this bond until fully reimbursed, less the actual cost of effecting the same, and less the amount of the deductible carried on the Employee causing such loss or losses; and any remainder shall be applied to the reimbursement of the Surety.

CANCELLATION AS TO ANY EMPLOYEE:

Section 9. This bond shall be deemed cancelled as to any Employee: (a) immediately upon discovery by the Obligee, or by any partner or officer thereof not in collusion with such Employee, of any fraudulent or dishonest act on the part of such Employee; or (b) at 12:01 A.M., Standard Time, upon the effective date specified in a written notice served upon the Insured or sent by mail. Such date, if the notice be served, shall be not less than ten days after such service, or, if sent by mail, not less than fifteen days after the date of mailing. The mailing by Surety of notice, as aforesaid, to the Obligee at its principal office shall be sufficient proof of notice.

CANCELLATION AS TO BOND IN ITS ENTIRETY:

Section 10. This bond shall be deemed cancelled in its entirety at 12:01 A.M. Standard Time, upon the effective date specified in a written notice by the Obligee upon the Surety or by the Surety upon the Obligee, or sent by mail. Such date, if the notice be served by the Surety, shall be not less than ten days after such service, or if sent by the Surety by mail, not less than fifteen days after the date of mailing. The mailing by the Surety of notice, as aforesaid, to the Obligee at its principal office shall be sufficient proof of notice. The Surety shall refund to the Obligee the unearned premium computed pro rata if this bond be cancelled at the instance of the Surety, or at short rates if cancelled or reduced at the instance of the Obligee

PRIOR FRAUD, DISHONESTY OR CANCELLATION:

Section 11. No Employee, to the best of the knowledge of the Obligee, or of any partner or officer thereof not in collusion with such Employee, has committed any fraudulent or dishonest act in the service of the Obligee or otherwise. If prior to the issuance of this bond, any fidelity insurance in favor of the Obligee or any predecessor in interest of the Obligee and covering one or more of the Obligee's employees shall have been cancelled as to any of such employees by reason of (a) the discovery of any fraudulent or dishonest act on the part of such employees, or (b) the giving of written notice of cancellation by the insurer issuing said fidelity insurance, whether the Surety or not, and if such employees shall not have been reinstated under the coverage of said fidelity insurance, or superseding fidelity insurance, the Surety shall not be liable under this bond on account of such employees unless the Surety shall agree in writing to include such employees within the coverage of this bond.

LOSS - NOTICE - PROOF - LEGAL PROCEEDINGS:

Section 12. At the earliest practical moment, after discovery of any potential fraudulent or dishonest act on the part of any Employee by the Obligee, or by any partner or officer thereof not in collusion with such Employee, the Obligee shall give the Surety written notice thereof and within 90 days after the criminal conviction of any employee covered under this bond, shall file with the Surety affirmative proof of loss, including a certified copy of the final disposition of the criminal action, and shall upon request of the Surety render every assistance, not pecuniary, to facilitate the investigation and adjustment of any loss. No suit to recover on account of loss under this bond shall be brought before the expiration of two months from the filing of proof as aforesaid on account of such loss, nor after the expiration of fifteen months from the discovery as aforesaid of the fraudulent or dishonest act causing such loss. If any limitation in this bond for giving notice, filing claim or bringing suit is prohibited or made void by any law controlling the construction of this bond, such limitation shall be deemed to be amended so as to be equal to the minimum period of limitation permitted by such law.

EXCLUSIONS:

Section 13. This bond does not apply:

- (a) to the defense of any legal proceeding brought against the Obligee or Subscriber, or to fees, costs or expenses incurred or paid by the Obligee or Subscriber in prosecuting or defending any legal proceeding whether or not such proceeding results or would result in a loss to the Obligee or Subscriber covered by this Bond.
- (b) to potential income including but not limited to interest and dividends, not realized by the Obligee or Subscriber because of a loss covered under this Bond.
- (c) to damages of any type for which the Obligee or Subscriber is legally liable, except direct compensatory damages arising from a loss covered under this Bond.
- (d) to costs, fees and other expenses incurred by the Obligee or Subscriber in establishing the existence of, or amount of, loss covered under this Bond.

SIGNED SEALED AND DATED _____

ProCentury Insurance Company

By: _____
Attorney-in-fact

ProCentury Insurance Company 465 Cleveland Avenue Westerville, Ohio 43082 614-895-2000 www.centurysurety.com	POLICY NUMBER PSB _____
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CRIME POLICY DECLARATIONS

NAMED INSURED & MAILING ADDRESS	AGENT'S NAME & ADDRESS												
<p>POLICY PERIOD: This policy is in force from _____ to _____ at 12:01 A.M. standard time at your mailing address shown above. In return for the payment of the premium, and subject to all the terms of this policy, we agree with you to provide the insurance as stated in this policy. These Declarations, together with the Common Policy Conditions, and the Crime Coverage Part (which consists of Coverage Forms and other applicable forms and endorsements, if any, issued to form a part of it) complete this policy.</p>													
Limits of Coverage													
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">Coverage</td> <td style="width: 30%; text-align: center;">Deductible Amount</td> <td style="width: 30%; text-align: center;">Amount of Insurance</td> </tr> <tr> <td></td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> </tr> <tr> <td></td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> </tr> <tr> <td></td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> </tr> </table>	Coverage	Deductible Amount	Amount of Insurance		\$	\$		\$	\$		\$	\$	
Coverage	Deductible Amount	Amount of Insurance											
	\$	\$											
	\$	\$											
	\$	\$											
<p>Forms and endorsements attached to this policy at the time of issuance:</p>													
<p>Cancellation of Prior Insurance: By acceptance of this Policy you give us notice canceling prior policy or bond number(s) _____, the cancellation to be effective at the time this Policy becomes effective.</p>													

Issue Date _____ At **Westerville, Ohio**
 By _____ Authorized Representative

IN WITNESS WHEREOF, this Company has executed and attested these presents; but this policy shall not be valid unless countersigned by the Company's duly Authorized Representative named above.



Erin E. West, CFO Treasurer and Secretary



Christopher J. Timm, President



BOND EXECUTION AND PREMIUM REPORT (Commercial Crime Policy)

Bond Number:	Insuring Company: Century Surety Company	Type of Charge: New Business	State / Agent Code
Agency:			
Location:			
Named Insured and Address		Joint Insured(s) , if any:	
Effective date:	Renewal Date:		
Total Premium: \$	Renewal Premium: \$		
Commission: %	Authorized By:		

Statistical Information

Class of Insured:	Rate Modification:	# of Ratable Employees.:	# of Add'l Loc.:
Policy/Coverage Type Code		11 Loss Sustained	
Premium	Coverage Amount	Deductible	Form
Description	Commission		
\$	\$	\$	01
Form A Schedule			%
\$	\$	\$	10
Form A Blanket/Form O			%
\$	\$	\$	12
Form A Specific Excess			%
\$	\$	\$	14
Business Services			%
\$	\$	\$	17
Form O Specific Excess			%
\$	\$	\$	20
Form P			%
\$	\$	\$	27
Form P Specific Excess			%
\$	\$	\$	90
Form B Personal Accts.			%
\$	\$	\$	96
Form B Forgery or Alt.			%
\$	\$	\$	98
Form B Warehouse Receipt			%
\$	\$	\$	99
Form B Cr/Debit/Ch Card			%
\$	Total		
Risk State:	Tax Town Code:	State Surcharge:	

Renewal Instructions

This Policy	Is Continuous		
Desired Term:	<input type="checkbox"/> Annual Payment	<input type="checkbox"/> Three Years	
Renewal Billing Method:	Agent Bill		
If Third Party Payee, Name & Address			

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADD FAITHFUL PERFORMANCE OF DUTY

This endorsement applies only to PUBLIC EMPLOYEE DISHONESTY COVERAGE FORM O or P.

PROVISIONS

1. The following is added as a Covered Cause of Loss:

Failure of any "employee" to faithfully perform his or her duties as prescribed by law, when such failure has as its direct and immediate result a loss of your Covered Property.

2. The following Additional Exclusion is added:

Depository Failure: loss resulting from the failure of any entity acting as a depository for your property or property for which you are responsible.

3. Part D.2.a.(1) of the Coverage Form is deleted and the following substituted:

Immediately upon discovery by you or any official or employee authorized to manage, govern or control your employees of any act on the part of an "employee" whether before or after becoming employed by you which would constitute a loss covered under the terms of this Coverage Form, as amended by this endorsement.

4. Part D.2.c. of the Coverage Form is deleted and the following substituted:

Indemnification: We will indemnify any of your officials who are required by law to give bonds for the faithful performance of their service against loss through the failure of any "employee" under the supervision of that official to faithfully perform his or her duties as prescribed by law, when such failure has as its direct and immediate result a loss of your Covered Property.

SERFF Tracking Number: CSIC-125710033 State: Arkansas
Filing Company: ProCentury Insurance Company State Tracking Number: #? \$50
Company Tracking Number: 135
TOI: 23.0 Fidelity Sub-TOI: 23.0000 Fidelity
Product Name: Fidelity Filing
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: CSIC-125710033 State: Arkansas
Filing Company: ProCentury Insurance Company State Tracking Number: #? \$50
Company Tracking Number: 135
TOI: 23.0 Fidelity Sub-TOI: 23.0000 Fidelity
Product Name: Fidelity Filing
Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty

Review Status: Approved 08/18/2008

Comments:

Attachment:

industry_rates_PCtransDoc_intelligent.pdf

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: New Business Renewal Business f. State Filing #: g. SERFF Filing #: h. Subject Codes
---	---

3. Group Name	Group NAIC #

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #

5. Company Tracking Number	
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail

7. Signature of authorized filer	
8. Please print name of authorized filer	

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	
10. Sub-Type of Insurance (Sub-TOI)	
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: <input type="text"/> Renewal: <input type="text"/>
15. Reference Filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Reference Organization (if applicable)	
17. Reference Organization # & Title	
18. Company's Date of Filing	
19. Status of filing in domicile	<input type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

***Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

PC TD-1 pg 2 of 2

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	
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2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	
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3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

PC FFS-1

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	
-----------	--	--

2.	This filing corresponds to form filing number (Company tracking number of form filing, if applicable)	
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Rate Increase
 Rate Decrease
 Rate Neutral (0%)

3.	Filing Method (Prior Approval, File & Use, Flex Band, etc.)	
-----------	--	--

4a.	Rate Change by Company (As Proposed)						
------------	---	--	--	--	--	--	--

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)

4b.	Rate Change by Company (As Accepted) For State Use Only						
------------	--	--	--	--	--	--	--

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)			
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		COMPANY USE	STATE USE
5a	Overall percentage rate indication (when applicable)		
5b	Overall percentage rate impact for this filing		
5c	Effect of Rate Filing – Written premium change for this program		
5d	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	
-----------	---	--

7.	Effective Date of last rate revision	
-----------	---	--

8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	
-----------	---	--

9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
02		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
03		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	