



Markel Insurance Company
 4600 Cox Road, Glen Allen, Va. 23060-9817
 800-431-1270, Fax 804-965-1689

MANAGEMENT VALUE PROTECTION
 Fiduciary Liability

EMPLOYEE STOCK OWNERSHIP PLAN SUPPLEMENT

1. Name of Applicant: _____
2. What was the reason(s) for establishing the ESOP? _____

3. When the ESOP was established, did it replace an existing employee benefit plan that was terminated? Yes No
If Yes, please provide details.
4. When the ESOP was established, was there unfavorable reaction by the employees or any plan participants? Yes No
If Yes, please provide an explanation.
5. Is the ESOP leveraged? Yes No **If Yes**, please provide the date, amount, financing and repayment terms for the loan, balance due, the parties selling shares to the ESOP, list any guarantors of the loan, and the reason(s) for the loan.
6. Value per share of the ESOP? _____
 Total number of shares held by the ESOP? _____
7. What percentage of the **“Applicant”** is owned by the ESOP? _____%
 Allocated Shares: _____
 Unallocated Shares: _____
8. Who votes the unallocated shares? _____
9. Is there representation for the ESOP on the board of directors? Yes No
If Yes, how many board positions are held by the ESOP participants? _____
10. Are there vesting requirements for the allocated ESOP shares? Yes No
If Yes, what time period is required? _____

The information contained herein becomes a part of your Markel Insurance Company Management Value Protection Application, and is subject to the same conditions as stated on such Application.

Must be signed by the Chief Executive Officer, President, or Chairman of the Parent Corporation

Name (Please print)

Title

Signature

Date

Produced by: Agent: _____ Agency: _____
Agency Taxpayer ID or SS No.: _____ Agent License No.: _____
Address (Street, City, State, Zip): _____

ADDITIONAL INFORMATION

You may use this page to provide additional information to any question on this application. Please identify the question number to which you are referring.

Signature

Date