TRAVELERS

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Employment Practices Liability Renewal Coverage Application

Travelers Casualty and Surety Company of America

NOTICE

ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST INSUREDS DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED BY THE AMOUNTS INCURRED AS DEFENSE EXPENSES, AND DEFENSE EXPENSES WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY CLAIM UNLESS DUTY–TO-DEFEND COVERAGE IS SPECIFICALLY PROVIDED.

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

I. GENERAL INFORMATION

1. **Applicant** Information:

   Name of **Applicant**: _____

   Street Address: _____

   City, State, ZIP Code: _____

   Expiring Policy Number: _____

2. Does the **Applicant** currently file, or does it anticipate filing in the next 6 months, any documents with the Securities and Exchange Commission, or similar foreign authority regarding any equity or debt securities? Yes ☐ No ☐

3. In the next 12 months (or during the past 24 months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) the following:

   a. Any actual or proposed merger, acquisition, or divestiture? Yes ☐ No ☐

   b. Any creation of a new business, subsidiary or division? Yes ☐ No ☐

   c. Any registration for a public offering or a private placement of securities? Yes ☐ No ☐

   d. Any reorganization or arrangement with creditors under federal or state law? Yes ☐ No ☐

   e. Any branch, location, facility, office, or subsidiary closings, consolidations or layoffs? Yes ☐ No ☐

   If any of the questions above were answered Yes, please attach an explanation, including the timing, the essential terms of the event, arrangement, impact on employee base, and the surrounding circumstances.

II. EMPLOYEE INFORMATION

1. Total number of employees*: _____

2. What percentage of the **Applicant's** employee base is outside the U.S.? _____ %

3. Total number of locations: _____

4. Complete the following chart providing the number of Full Time and Part Time employees*, Volunteers and natural person Independent Contractors:

As of Date of Application		Previous 12 Months		As of Date of Application	
Full Time Employees	**Part Time Employees**	**Full Time Employees**	**Part Time Employees**	**Volunteers**	**Independent Contractors**

*Full and part time including leased, seasonal, and temporary employees

5. Complete the following chart providing the *maximum* number of employees at any one point during the previous 12 months for the following classifications (regardless of whether they are full or part time):

Leased	Temporary	Seasonal	Union

6. Complete the following chart providing employee information for the 5 states or countries with the greatest number of **Applicant** employees:

State or Foreign Country Location	Number of Employees

7. Complete the following chart providing employee turnover figures for each of the last 3 years:

Number of Terminations	Year - 20____	Year - 20____	Year - 20____
Voluntary			
Involuntary (excluding layoffs/downsizing)			
Layoffs/Downsizing			

8. Within the past 24 months how many officers have been involuntarily terminated or laid off? _____

9. Prior to employee terminations does the **Applicant** consult with:

   a. Human Resources personnel? Yes ☐ No ☐

   b. An attorney with experience in employment law? Yes ☐ No ☐

III. HUMAN RESOURCES

1. During the past 12 months, has the **Applicant** made amendments to any Human Resources policies or procedures or Employee Handbook? Yes ☐ No ☐
   If Yes, please provide copies of such policies or procedures or handbook.

   a. If Yes, were the changes reviewed by legal counsel? Yes ☐ No ☐

IV. REQUESTED INSURANCE TERMS

1. Does the **Applicant** desire any changes to the expiring policy limit or retention? Yes ☐ No ☐
   If Yes, please indicate the desired changes in the table below:

Expiring Limit (A)	Requested Limit (B)	Expiring Retention (C)	Requested Retention (D)
$	$	$	$

Do not answer the next question unless the Requested Limit in Column (B) exceeds the Expiring Limit in Column (A).

2. Solely with respect to the higher limits requested or that may ultimately be issued for the proposed renewal, is the **Applicant** or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under the Liability Coverage? Yes ☐ No ☐
   If Yes, please attach an explanation.

*Solely with respect to any portion of the Limit for this Liability Coverage in the proposed policy that exceeds the amount of the Expiring Limit for this Liability Coverage in the expiring policy, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of the **Applicant** had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy.*

V. REQUIRED ATTACHMENTS

As part of this Application, please submit the following documents (*these documents, and the representations and facts they contain, are made a part of this Application, whether such documents are physically delivered to the Company by the **Applicant** or are obtained by the Company from any public source, including the Internet*):

- Most recent EEO-1 report, if **Applicant** has 1,000 or more employees
- Most recent annual financial statement
- Downsizing Supplemental Application, if impact of **Applicant** layoffs is either 10% of the workforce or more than 100 employees

VI. COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

VII. FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island
Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Attention: Insureds in Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania
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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and Washington
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Attention: Insureds in Oregon
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Puerto Rico

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VIII. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PARTNER, PRINCIPAL, HEAD OF HUMAN RESOURCES, GENERAL COUNSEL OR OTHER OFFICER ACCEPTABLE TO TRAVELERS) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Signature* of **Applicant's** Authorized Representative (Partner, Principal, Officer, Head of Human Resources or General Counsel)

Name (Printed)

Title

Date

***IF YOU ARE ELECTRONICALLY SUBMITTING THIS APPLICATION TO TRAVELERS, APPLY YOUR ELECTRONIC SIGNATURE TO THIS FORM BY CHECKING THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX BELOW. BY DOING SO, YOU HEREBY CONSENT AND AGREE THAT YOUR USE OF A KEY PAD, MOUSE, OR OTHER DEVICE TO CHECK THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX CONSTITUTES YOUR SIGNATURE, ACCEPTANCE, AND AGREEMENT AS IF ACTUALLY SIGNED BY YOU IN WRITING AND HAS THE SAME FORCE AND EFFECT AS A SIGNATURE AFFIXED BY HAND.**

AUTHORIZED REPRESENTATIVE'S ELECTRONIC SIGNATURE AND ACCEPTANCE ☐

IX. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE):

Producer Signature

Producer Name (Printed)

Agency Name

Agency Code

License Number